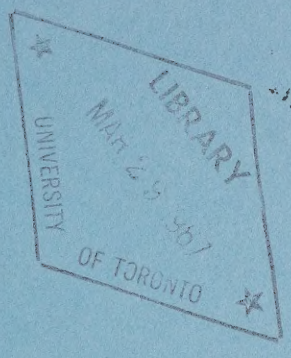
Health and welfare services in Canada
1967

HEALTH AND WELFARE SERVICES IN CANADA



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This booklet contains the material contributed by the Research and Statistics Directorate for inclusion in the chapter, "Public Health, Welfare, and Social Security" of the Canada Year Book. Certain material is included which was omitted from that chapter in the interests of brevity. Sections contributed to it by other agencies are of course not included.

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HEALTH AND WELFARE SERVICES

IN CANADA

INTRODUCTION

Canada's growth in recent years has intensified many problems in the planning of health and welfare services, and has shifted the emphasis toward new approaches and new programs. General prosperity, growing urbanization and industralization, larger numbers of children and older persons in the population, and new concepts and knowledge in health and welfare matters have all contributed to needs for additional services.

With the April 1965 Throne Speech, Canada embarked on its "War on Poverty", a program for the full utilization of human resources and the elimination of poverty. Among the planned measures will be an expansion of the Area Development Program (ADA) and the Agricultural Rehabilitation and Development Program (ARDA) measures to assist the re-employment, relocation and retraining of workers, urban renewal measures, establishment of a Company of Young Canadians to undertake projects for economic and social development in Canada and abroad, and the establishment of a Canada Assistance Plan. These and related matters were discussed at the Federal-Provincial Conference on Poverty and Opportunity held in Ottawa in December 1965.

The first Canadian Conference on Aging, sponsored by the Canadian Welfare Council and held in Toronto in January 1966, sought ways and means of improving the life of older people. Delegates represented labour, management, professional organizations, voluntary organizations and the churches. The report of the Special Committee of the Senate on Aging, released in February 1966, recommends a guaranteed income for older people, improvements in housing, health and institutional care, social services, community participation, recreation programs, and the establishment of a national commission on aging.

The Act to establish the Canada Pension Plan, which was given Royal Assent on April 3, 1965 and became operational on January 1, 1966, established for the first time in Canada a comprehensive social insurance program of contributory, old age, disability, and survivors' pensions. The legislation provides an earnings-related old age pension and adjusts the existing tax-financed flat-rate Old Age Security pension so that the two programs form an integrated system. It also provides a program of supplementary pensions and benefits for disabled contributors and their dependent children, and survivors of contributors.

The province of Quebec established the Quebec Pension Plan, which came into operation on January 1, 1966. The Canada Pension Plan does not operate in Quebec because the legislation provides that the Plan will not be operative in a province that establishes its own comparable program. It is significant that both the Parliament of Canada and that of Quebec have passed almost identical legislation in this field. The two plans are to be so closely co-ordinated that a person may contribute under one plan or the other, or to both plans interchangeably, during his contributory period and receive the same benefits as if he had contributed to one plan throughout this period.

The introduction of the Canada and Quebec pension plans emphasized the need for uniform private-pension legislation across Canada. Ontario amended the Ontario Pension Benefits Act with effect from July 30, 1965. In the province of Quebec the Supplemental Pension Plans Act was given Royal Assent on July 15, 1965. Both Acts regulate private pension plans, ensure portability and solvency of the private plans, and require the provision of information to the members of the plan.

An amendment to the Old Age Security Act lowered the eligible age, provided for adjustment of the amount of the pension for increases in the cost of living, and eased residence requirements.

The Canada Assistance Act, which was given Royal Assent on July 14, 1966, provides for a comprehensive welfare system to replace the categorical programs of Old Age Assistance, Blind and Disabled Persons' Allowances and Unemployment Assistance; extends existing social assistance and welfare coverage; and substitutes a needs test for a test of means as a qualification for assistance. Provincial programs for persons in need, including health care services, will be financially supported by federal-provincial cost-sharing arrangements.

In the health field, the federal government proposed at a Federal-Provincial Conference in July 1965 that a comprehensive medical care insurance program be introduced. It announced its willingness to make fiscal contributions, beginning July 1, 1967, toward provincial medical care insurance plans meeting four specified criteria; these are that the plans be comprehensive, universal, public, and transferable. The Federal Medical Care Act which embodies these principles was given first reading on July 12, 1966, with further debates postponed until October. On September 1, 1965 the British Columbia Medical Plan took effect, and on July 1, 1966 the Ontario Medical Services Insurance Plan and the Alberta Health Program (an extension of the former Alberta Medical Plan) began paying benefits. These three provincial plans are voluntary and involve subsidization of premiums for low income groups.

Supplementing the proposed medicare program, the Prime Minister also proposed at the July 1965 Conference to establish a Health Resources Fund that would "support the construction and equipment of facilities for health research and training". The Health Resources Fund Act providing $500 million to assist the provinces in the acquisition, construction and renovation of such facilities during the period 1966-1980, was enacted by Parliament in July 1966.

PART I - PUBLIC HEALTH

Provincial governments bear the major responsibility for health services in Canada, with the municipality often assuming considerable authority over matters delegated to it by provincial legislation. The federal government has jurisdiction over a number of health matters of a national character and provides important financial assistance to provincial health and hospital services. All levels of government are aided and supported by a network of voluntary agencies working in different health fields.

Section 1 - Federal Health Activities

The Department of National Health and Welfare is the chief federal agency in health matters but important treatment programs are also administered by the Departments of Veterans Affairs and National Defence. The Dominion Bureau of Statistics is responsible for collection, analysis, and publication of national health statistics, the Medical Research Council and the Defence Research Board administer medical research programs, and the Department of Agriculture has certain health responsibilities connected with food production.

The Department of National Health and Welfare controls food and drugs, including narcotics, operates quarantine and immigration medical services, carries out international health obligations, and provides health services to Indians, Eskimos, and other special groups. It advises on the visual eligibility of applicants for blindness allowances and co-operates with the provinces in the provision of surgical or remedial treatment for recipients of the allowances. Under the Public Works Health Act, supervision of health conditions is provided for persons employed on federal public works. Health counselling and medical supervision are provided for the federal Civil Service. The Department also administers the civil aviation medical program for the Department of Transport.

Subsection 1 - Food and Drug Control

The Food and Drugs Act, administered by the Food and Drug Directorate of the Department of National Health and Welfare, is a federal statute with provisions applying to the manufacture, advertising, packaging, and sale of foods, drugs, cosmetics, and medical devices anywhere in Canada. Wide powers are authorized under this legislation to maintain the safety, purity, and quality of food and drug products and to prevent misrepresentation in labelling and advertising. There are prohibitions, for example, on the sale of food or drugs that do not meet prescribed standards, are harmful, adulterated, dirty, improperly stored, or manufactured under unsanitary conditions. The Act also prohibits the advertising of any food, drug, cosmetic, or medical device as a preventive or cure for a number of serious diseases and also lists drugs that may be sold only by prescription.

Standards of safety and purity are maintained through constant and widespread inspection and laboratory research. The inspection of food-manufacturing establishments plays a major role in the production of clean, wholesome foods containing ingredients that meet recognized standards. Changing food technology requires the development of methods of laboratory analysis to ensure the safety of new types of ingredients and packaging materials. The Food and Drug Regulations were amended in 1964 by the addition of sections listing chemical additives that may be used in foods, the amounts that may be added to each food, and the underlying reason. Considerable emphasis is placed upon studies to ensure that the levels of pesticide residues in foods do not constitute a health hazard. The effect of new packaging and processing techniques on the bacteria associated with food spoilage is another matter of special concern. Since the Food and Drugs Act is intended for the protection of consumers, a section of the Food and Drug Directorate obtains consumer opinions, deals with individual consumer complaints, and provides information on which consumers can base opinions.

Drug standards are subject to continuous review and testing. Detailed information on all new drugs must be reviewed by the Directorate to determine compliance with requirements before release for sale is permitted. In 1963, important drug regulations were promulgated, one setting standards for drug manufacturing, facilities and controls, and the second prescribing additional safeguards in the distribution of investigational and new drugs. Drug manufacturing requirements relate to sanitation of facilities, employment of qualified personnel, testing to ensure standards of quality and safety

at stated stages of processing, maintenance of records of testing performance, together with a system of control to enable a complete and rapid recall of any lot or batch of drugs from the market. The new controls over clinical trials and marketing of new drugs require detailed information to be submitted to the Directorate concerning the method of manufacture, the tests applied to establish standards of safety and quality, and substantial evidence of the clinical effectiveness of the new drug for the purposes stated. Samples of the final product must also be submitted. Before carrying out clinical trials a manufacturer also must file complete data on his experience with the drug including any evidence of adverse side effects, and the qualifications of the persons to be engaged in its investigational use. The Minister may suspend clinical testing based on this evidence if he feels that it is in the public interest to do so. In the case of suspension of the clinical trials, the manufacturer has the right to appeal the decision. Drugs expressly prohibited from sale are thalidomide and lysergic acid diethylamide, except under certain conditions, as specified in the regulations whereby sale by a manufacturer to an institution for clinical use or laboratory research by qualified investigators may be approved by the Minister. Any drug that can be classed as a sedative, hypnotic, or tranquillizer is listed to be sold only on prescription. The licensing of persons dealing in certain drugs classed as barbiturates and amphetamines is required as well as the keeping of special records and the limitation of their use to medical purposes.

The Food and Drug Directorate also administers the Proprietary or Patent Medicine Act, which is concerned with the voluntary registration before marketing and the annual licensing of home medicines sold under proprietary or trade names.

Early in 1965 the Directorate initiated an adverse-drug-reaction reporting program in 16 teaching hospitals across Canada to recognize and investigate reactions to drugs. The co-operation of the medical, dental, veterinary, and pharmaceutical professions was solicited in advising the Directorate of such reactions in private practice. Close liaison is maintained with the World Health Organization and other authorities in foreign countries for the prompt reporting of such reactions.

Regulation of the supply and use of narcotic drugs is carried out under the Narcotic Control Act, as revised in 1961. This legislation prescribes a maximum penalty of seven years with no minimum for illegal possession; a maximum penalty for trafficking of life imprisonment; and minimum and maximum penalties for illegal export and import of seven years and life imprisonment, respectively. The Royal Canadian Mounted

Police and other law enforcement agencies continue to make every effort to keep the illicit traffic to a minimum. The fact that our total convictions over recent years have maintained fairly constant if not a declining level, indicates the success of these efforts, particularly when it is taken into consideration that our population continues to increase steadily.

Subsection 2 - Medical Services

The Department of National Health and Welfare provides both directly and indirectly several types of direct medical service through the Medical Services Branch. These are described in the following paragraphs. Indirect services are provided by hiring locally available services where practicable.

Indians and Eskimos. - The Department of National Health and Welfare provides medical and public health services to registered Indians or Eskimos who are not included under provincial arrangements and who are unable to provide for themselves. A large volume of the service in treatment and health education is rendered to patients through 84 departmental out-patient clinics staffed by medical and other public health personnel. In remote areas, the key facility is frequently the departmental nursing station, a combined emergency treatment and public health unit having two to four beds under the direction of one or two nurses; 43 of these are operated throughout Canada.

Wherever practicable, there has been an increasing integration of Indians into provincial and municipal health agencies. The Department correspondingly reduces the number of hospitals and other facilities provided specifically for Indians. At present the Department maintains 16 hospitals at strategic points and co-operates elsewhere with community, mission, or company hospitals. Indians are now included under all provincial prepaid insurance plans for hospital care and other forms of insured medical care but in almost all cases the cost of mental and tuberculosis care is directly borne by the federal government. Indian and Eskimo health workers are trained to give instruction in health care and sanitation.

Northern health. - Because of the special problems in developing health services in the Far North, the Department of National Health and Welfare has been given the responsibility of co-ordinating federal and territorial health care for all residents. In so doing, the Department undertakes the functions of a health department for the Council of the Northwest Territories and assists the territorial government of the Yukon Territory to provide certain health services.

A close liaison is maintained with the federal departments directly responsible for administrative matters affecting these areas.

In the Yukon Territory, services for the total population administered through the Commissioner for the Yukon and provided on a cost-sharing basis with the Department of National Health and Welfare include complete treatment for tuberculosis, payment for services rendered at the Alberta cancer clinics, mental hospital care through arrangements with the Province of British Columbia, and medical care for indigent patients. Public health nursing services, measures for control of communicable diseases, and administration of the principal public hospital are primarily the responsibility of the Medical Services of the Department of National Health and Welfare.

In the Northwest Territories similar services are provided, the costs being shared by the Department of Northern Affairs and National Resources and the Department of National Health and Welfare. Indigent residents are eligible for medical, dental, and optical services as well as for tuberculosis and mental care.

Sick mariners. - The Department of National Health and Welfare provides compulsory prepaid medical, surgical, hospital, and other treatment services to crew members of all foreign-going ships arriving in Canada and Canadian coastal vessels in interprovincial trade, and provides medical, surgical, and treatment services on an elective basis to crew members of Canadian fishing and government vessels. (Canadian seamen obtain their hospital care under the provincial hospital insurance plans.)

Leprosy. - Since 1960, isolation and treatment of persons suffering from leprosy have been arranged in their home neighborhoods. Under the provisions of the Leprosy Act, facilities for the diagnosis and treatment of leprosy are provided in a six-bed unit of the Hôtel-Dieu Hospital at Tracadie, New Brunswick.

Quarantine. - Under the Quarantine Act all vessels, aircraft, and other conveyances and their crew and passengers arriving in Canada from foreign countries are inspected by the quarantine officers to detect and correct conditions that could lead to the entry into Canada of such diseases as smallpox, cholera, plague, yellow fever, typhus, and relapsing fever. Fully organized quarantine stations are located at all major seaports and airports.

Immigration. - Under the Immigration Act and the Department of National Health and Welfare Act, the Immigration Medical Service conducts in Canada and other countries the

medical examination of all applicants for immigration to Canada and also provides treatment for certain classes of persons after arrival in Canada, including immigrants who become ill en route to their destination or while awaiting employment.

Civil service health counselling. - Health counselling is offered through Medical Services units to federal employees throughout the country. This service is primarily diagnostic and advisory only, but emergency treatment can also be given. The Civil Service Health Counselling Division also examines civilian aviation personnel and advises on standards of physical fitness required for them.

Aerospace medicine. - Research on civil aerospace medicine is conducted by the Department in close liaison with the National Research Council, the Defence Research Board, and the Royal Canadian Air Force Institute of Aviation Medicine.

Regulation of hygienic standards. - The Department of National Health and Welfare is responsible for regulating hygienic standards on federal property, interprovincial common carriers, Canadian shipping and aircraft.

Coast Guard medical service. - The Department has recently agreed to provide a medical service for and in conjunction with the Canadian Coast Guard Service.

Subsection 3 - Health Research

Health research in Canada is carried on in universities, hospitals, research institutions, and government departments. The main sources of financial support are governments, voluntary agencies, charitable foundations, professional bodies, and business corporations.

The federal government conducts medical and dental research itself (intramural research) in the Department of National Health and Welfare and the Defence Research Board. The Medical Research Council, the National Research Council, the Department of National Health and Welfare, the Department of National Defence, the Department of Veterans Affairs, and the Queen Elizabeth II Fund all give financial support to research in universities, hospitals, and other institutions (extramural research).

The Medical Research Council, formed in 1960 from the National Research Council's former Division of Medical Research, is the principal federal health-research advisory and co-ordinating agency. Its primary concern is the support of

fundamental research in the basic medical sciences. It administers most of the federal medical research grants that support full-time investigation by research scientists in Canadian medical schools and their affiliated hospitals.

The National Research Council pursues in its broad program many investigations relevant to health. Its Associate Committee on Dental Research administers specific grants for dental research and training dental-research personnel.

The Department of National Health and Welfare supports both extramural and intramural health research, chiefly of an applied nature. Intramural research is carried on by the Food and Drug Directorate, the Medical Services Directorate, the Health Insurance and Resources Branch, by several divisions and laboratories of the Health Services Branch, and by the Research and Statistics Division. The Department's extramural research program is composed of public health research, surveys and studies that have the prior approval of the provinces for assistance under the National Health Grants Program. Assisted projects mainly fall into one of the following areas:

(a) prevention of disease and disability,

(b) operational or administrative research on health programs and services,

(c) epidemiological studies,

(d) environmental health, sanitation, and public health engineering.

The Defence Research Board sponsors both intramural and extramural research on medical problems of defence interest. In addition, a special unit to conduct research in aviation medicine has been established at McGill University.

The Department of Veterans Affairs maintains a program of medical research in its hospitals and clinics across Canada, mainly dealing with conditions affecting aging, such as arthritis and arteriosclerosis, which the Department is particularly able to investigate.

The Queen Elizabeth II Fund for Research in the Diseases of Children, established by the federal government in 1959, makes a fixed annual sum available for training researchers and scientists in childrens' diseases.

Subsection 4 - Radiation Protection

A comprehensive radiation protection program has been developed in Canada in response to the rapidly increasing use of radioactive materials, X-ray equipment, and nuclear reactors in medicine, industry, and research, and to increasing concern about radiation from atmospheric testing of nuclear weapons, from medical X-ray procedures, and from natural sources.

Because of technical complexity in this new field and the necessity of imposing national controls over uranium and its by-products, the federal government has developed procedures for the safe handling and use of all radioactive materials. These procedures are implemented through the close collaboration of federal and provincial health departments, supported by special advisory committees.

Acting under the federal Atomic Energy Control Regulations, the Department of National Health and Welfare reviews all applications for radioisotope licenses and recommends health and safety conditions. The Department also provides dosimetry services for measuring and recording the personal radiation exposures of workers handling beta-ray, gamma-ray, and neutron sources. Licensed establishments are inspected by federal or provincial officers.

Although there is no federal regulatory authority to provide health and safety supervision over the use of X-rays, the Department of National Health and Welfare has established a committee on the development of X-ray safety standards to recommend uniform standards and procedures throughout Canada. Five provinces (Nova Scotia, Quebec, Ontario, Saskatchewan, and Alberta) have already enacted specific enabling legislation applicable to X-rays, and two (Nova Scotia and Saskatchewan) have issued regulations requiring registration of operators and/or equipment. The Department's personnel dosimetry service is available to X-ray workers, and its reports are provided to the provincial departments of health.

The Department of National Health and Welfare serves as the co-ordinator for federal departments and agencies that are capable of providing specialized radiation protection services, particularly in the event of radiation accidents involving possible exposure of members of the public. The Department also provides "whole-body counting" and bio-assay facilities for the follow-up of persons who may have ingested or inhaled radioactive contamination.

As a supplement to its safety assessment and control program, the Department provides short-term training courses in radiation protection for persons with varying degrees of responsibility for radiation protection on a day-to-day basis.

Special attention is given to the health and safety problems associated with the siting, design, construction and operation of nuclear reactors and charged-particle accelerators. Committees of the Atomic Energy Control Board, including federal and provincial health department representatives, review these matters.

For the nuclear reactors in Ontario and Manitoba, the Department of National Health and Welfare and the provincial departments of health collaborate in environmental monitoring programs to ensure that the operation of the reactors does not result in the gradual build-up of radioactive contamination to levels of significance to the health of the people in the surrounding communities. The Department of National Health and Welfare also provides a special "criticality" dosimeter service for reactor operators and others handling fissile material.

A comprehensive nation-wide monitoring program has been developed to assess the exposure of the public to radiation from radioactive fallout from nuclear-weapons testing. The Department is assisted in the systematic collection of samples of air, precipitation, soil, wheat, milk and human bone by the federal Departments of Transport and Agriculture and by pathologists in hospitals throughout Canada. Reports of the concentration of such fallout components as strontium-90 and cesium-137 in these samples are published monthly. Because of a unique food-chain cycle in the Far North, a special study of cesium-137 in the North has been added to the nation-wide program. This includes meansurements of cesium-137 in caribou and reindeer meat and in human urine. In addition, direct measurements of cesium-137 in living persons are made using both a portable and a fixed whole body counter.

The Department of National Health and Welfare also conducts biological research programs related to radiation protection. Studies currently underway include one related to the high cesium-137 levels observed in the North - it is a study intended to determine more precisely the mechanisms involved in the metabolism of cesium-137. Another study involves an attempt to develop a practicable technique for assessing an individual's radiation exposure by changes in some radiosensitive biological indicator.

Subsection 5 - Consultative and Technical Services

The extension of technical and consultative assistance to the provinces is a function of the Health Branch of the Department of National Health and Welfare. Among the specialized services that supply consultation and information, advise on health care projects, co-ordinate activities and planning and exercise

leadership in promoting high standards of service are the following: Aerospace Medicine and Safety; Child and Maternal Health; Dental Health; Emergency Health; Epidemiology; Health Education; Laboratory of Hygiene; Medical Rehabilitation; Mental Health; Nursing Service; Nutrition; Occupational Health; Planning and Evaluation; Public Health Engineering; Research Development; Health Grants; Health Resources; Hospital Insurance and Diagnostic Services; Health Facilities Design; Medical Care; and Research and Statistics.

Section 2 - Federal-Provincial Health Activities

The Department of National Health and Welfare serves the provinces in an advisory and co-ordinating capacity and administers grants to provincial and voluntary health agencies. Administration of federal aspects of the Hospital Insurance and National Health Grant programs has become a major activity during the past decade. Co-ordination with the provinces on health matters is facilitated by the Dominion Council of Health.

Subsection 1 - Medicare

Proposals for a plan of comprehensive medical insurance for all Canadians, administered by the provinces and with federal fiscal contributions, were made by the Prime Minister at the Federal-Provincial Conference in July 1965. The federal contributions would be dependent upon the fulfilment of four criteria by each provincial plan. The first is that it should cover, as a minimum, "all the services provided by physicians, both general practitioners and specialists", except for services available under other legislation and certain limited types of services, such as cosmetic surgery that is not medically necessary. The second criterion is that it cover all residents, or at least "be aimed at universal coverage", without exclusion because of age, economic circumstances, or pre-existing conditions. The third criterion is that it be "publicly administered, either directly by the provincial government or by a provincial government agency". The fourth is that benefits be fully transferable from one province to another. The federal contribution would be half the per capita cost of all insured services in all participating provinces multiplied by the number of insured persons in each participating province. The Medical Care Act, which embodies these principles, was given first reading in the House of Commons on July 12, 1966.

Subsection 2 - Health Resources Fund

Supplementing the medicare program, the Prime Minister proposed the setting up of a Health Resources Fund to "support the construction and equipment of facilities for health research and training". On September 23, 1965 he announced that the amount of the proposed fund would be $500 million over a 15-year period commencing in 1966. He said, "The basic purpose of the fund is to help meet the greater need for trained people to provide medicare services. Through the fund, federal capital grants will be available for the construction, renovation and basic equipment of research establishments, teaching hospitals, medical schools and training facilities for other health personnel. Grants from the fund will not be available to meet the operating costs of such establishments." Payments from the fund would meet 50 per cent of the cost of construction and basic equipment for the assisted projects.

The Federal-Provincial Conference of Health Ministers on January 31 and February 1, 1966, discussed the operation of the proposed Health Resources Fund. They accepted the principle that, of the $500 million, $25 million would be provided to the four Atlantic Provinces as special assistance over and above the normal 50 per cent share, and that a major portion would be allocated on a per capita basis. The allocation of the remainder was left for further study.

An advisory committee, to consist of representatives of federal and provincial ministers of health, would, it was intended, review overall provincial submissions concerning individual projects, would advise on disbursements from the fund, and would consult with professional bodies for technical advice.

Two technical conferences were held (October 21-22, 1965, and March 31 - April 1, 1966) to make preliminary and tentative arrangements for the implementation of the proposed program.

The Health Resources Fund Act was passed by the House of Commons June 27, 1966.

Subsection 3 - National Health Grant Program

The National Health Grant program, inaugurated in 1948, makes federal grants available to the provinces for the developing and strengthening of public health and hospital services. Originally there were nine continuing grants: the Hospital Construction, Professional Training, General

Public Health, Public Health Research, Mental Health, Tuberculosis Control, Cancer Control, Venereal Disease Control, and Crippled Children Grants. One other, the Health Survey Grant, lapsed in 1953 after the completion of provincial health surveys. In 1953 three new grants were established: Child and Maternal Health, Medical Rehabilitation, and Laboratory and Radiological Services.

In 1958, federal assistance under the Hospital Construction Grant was increased to $2,000 per hospital bed (whether active treatment, chronic, mental, or tuberculosis), double the previous grant for active treatment beds. In addition, funds were made available to meet up to one-third of the cost of approved alterations and renovations to existing facilities, with the federal contributions being at least matched by the provinces.

Beginning with the fiscal year 1960-61, a redistribution and merging of certain grants was effected to provide a more flexible measure of assistance and at the same time make larger amounts available for programs where additional aid was necessary. Adjustments were also required for services aided under certain grants, such as laboratory and radiological services and cancer control, now aided under the Hospital Insurance program. The total allocation remained approximately the same but the number of separate grants was reduced to nine. The General Public Health Grant was increased by almost $5,500,000 and projects under two previously separate grants -- the Laboratory and Radiological Services Grant and the Venereal Disease Control Grant -- were absorbed into it. The Medical Rehabilitation and Crippled Children Grants were merged and their combined allocation increased by more than $1,000,000. The Mental Health Grant was increased by more than $1,500,000 and the Professional Training and the Public Health Research Grants by about $1,250,000 each. The Tuberculosis Control Grant was decreased by nearly $750,000 and the Child and Maternal Health and Cancer Control by lesser amounts. The grants for professional training and public health research, previously fixed amounts, were placed on a per capita basis, to increase with expansion of the population.

In February, 1966, the Government announced its intention to continue the Hospital Construction Grant to March 31, 1970 -- an extension of two years beyond its anticipated expiry date.

During the fiscal year 1965-66 the following Health Grants were in force: Hospital Construction, Mental Health, Tuberculosis Control, Cancer, Medical Rehabilitation and Crippled Children, Professional Training, Public Health Research, Child and Maternal Health, and General Public Health.

Up to March 31, 1966, aid for hospital construction had been approved for 122,176 beds and 15,359 bassinets for patients, 23,355 beds for nurses, and 917 beds for interns.

Approximately 42,000 health workers had been trained or were undergoing special training, and more than 7,000 health workers were employed, with Health Grant Assistance. The amount expended in 1965-66 totalled $45,477,968 or 75 per cent (Table 1) of the amount available; over the entire eighteen years of the program, 79 per cent of the available moneys had been actually spent. If for 1965-66 the $5,900,000 in fiscal compensation received by Quebec is deducted from the total available, the total is reduced to $50,880,280 and the amount expended in the rest of Canada appears as 89.4 per cent of the available amount.

Subsection 4 - Hospital Insurance

The federal-provincial hospital insurance program, now established in all provinces and territories, covers 98.7 per cent of the total population of Canada. This program was introduced under the federal Hospital Insurance and Diagnostic Services Act of 1957, by which the federal government shares with the provinces the costs of providing specified hospital services to insured patients. The choice of methods of financing and administering the program at the provincial level, and the choice of the types of service offered above the minimum stipulated in the Act, rest with the provinces.

Federal legislation covers only services in institutions approved to provide acute, chronic, and convalescent care. Tuberculosis and mental hospitals are excluded from the federal-provincial plan, as are institutions providing custodial care. However, the psychiatric and tuberculosis units of general hospitals are included in the program.

The basic range of in-patient benefits that, under the Act, each province is required to provide includes standard ward accommodation and meals, nursing service, drugs and biologicals, surgical supplies, the use of operating and case rooms, diagnostic procedures (including X-ray and laboratory procedures) together with the necessary medical interpretations, and the use of radiotherapy and physiotherapy facilities where available. The same benefits for out-patients, although authorized for assistance under the federal legislation, are not mandatory upon provincial plans. All provinces except one provide under the plan some insured out-patient services. The pattern varies from province to province, but among the services offered are emergency care following accidents, diagnostic services, and therapeutic services, including minor surgical and medical procedures. Some provinces provide certain psychiatric out-patient services.

TABLE 1 - AMOUNTS AVAILABLE AND AMOUNT AND PERCENTAGES EXPENDED UNDER THE NATIONAL HEALTH GRANT PROGRAM, BY GRANT, FOR THE EIGHTEEN-YEAR PERIOD ENDED MARCH 31, 1966, AND FOR THE YEAR ENDED MARCH 31, 1966

Grant	1948-1966 period			Year ended March 31, 1966		
	Amount (1) available	Amount expended	Percentage expended	Amount available	Amount expended	Percentage expended
Crippled Children (2)	6,207,728	4,431,677	71	-	-	-
Professional Training	17,191,644	15,644,345	91	1,923,700	1,280,025	66
Hospital Construction	252,419,132	233,945,344	93	20,367,320	17,622,038	86
Venereal Disease Control (3)	5,968,336	5,146,209	86	-	-	-
Mental Health	126,734,488	104,502,806	82	8,656,650	5,909,861	68
Tuberculosis Control	67,968,562	62,979,909	93	1,923,700	1,719,316	89
Public Health Research	18,640,558	16,286,456	87	4,424,510	4,214,560	95
Health Surveys (4)	645,180	540,960	84	-	-	-
General Public Health	173,624,051	121,797,929	70	16,351,450	10,840,170	66
Cancer Control	62,489,353	44,957,713	72	1,923,700	1,132,757	59
Laboratory & Radiological Services (5)	47,404,300	14,450,881	30	-	-	-
Medical Rehabilitation (6)	6,500,000	3,016,750	46	-	-	-
Medical Rehab. & Crippled Children (7)	16,410,550	10,512,555	64	2,885,550	1,839,477	64
Child and Maternal Health (8)	22,173,700	15,076,033	68	1,923,700	919,764	48
Total	824,377,582	653,289,567	79	60,380,280	45,477,968(9)	75

(1) Amounts as set out in the Orders-in-Council.
(2) Merged with Medical Rehabilitation Grant, April 1, 1960.
(3) Absorbed into General Public Health Grant, April 1, 1960.
(4) Lapsed in 1953 following the completion of provincial health surveys.
(5) Introduced in 1953 and absorbed into General Public Health Grant, April 1, 1960.
(6) Introduced in 1953 and merged with Crippled Children Grant, April 1, 1960.
(7) Amounts for 1960-66 only; see footnotes 2 & 6.
(8) Introduced in 1953.
(9) Total expended excludes an estimated amount of $9,500,000 that represents Quebec entitlement under the Established Program (Interim Arrangements) Act.

Provinces use different methods of administering and financing their programs, and establishing eligibility for benefits. In some provinces the hospital insurance program is administered by the Department of Health, in others by a separate hospital services commission. Moneys raised through general revenues, provincial sales taxes, and personal premiums are used separately and in combination, in different provinces. In the provinces where no premium system applies, residence in the province is the determining factor of eligibility for benefits; in the provinces with a premium system, eligibility for benefits is dependent upon payment of the premium as well as fulfilment of the residence requirements. Coverage is universal in provinces where no premiums are levied, and it is either automatic or compulsory in all provinces except Ontario, where participation in the insurance program is voluntary for certain groups of people.

Under the cost-sharing formula specified in the Hospital Insurance and Diagnostic Services Act, the federal government pays each province 25 per cent of the per capita cost of in-patient services in Canada as a whole plus 25 per cent of the per capita cost of in-patient services in the province, multiplied by the average for the year of the number of insured persons in the province. On a national basis, the federal contribution amounts to about 50 per cent of sharable costs. However, for individual provinces the proportion of sharable costs met by the federal government varies, with a higher proportion of the cost of low-cost programs than of high-cost programs being met. Federal payments to the provinces under the program from July 1, 1958 to December 31, 1965, totalled almost $2,100,000,000. Since January 1, 1965, payments have no longer been made by Canada to the province of Quebec under the hospital insurance program, the financial arrangements having been transferred to a system of tax abatement. During 1965, federal payments to the individual provinces and territories totalled $327,000,000 divided as follows: Newfoundland, $11,100,000; Prince Edward Island, $2,300,000; Nova Scotia, $17,200,000; New Brunswick, $14,100,000; Ontario, $162,200,000; Manitoba, $22,100,000; Saskatchewan, $24,500,000; Alberta, $33,400,000; British Columbia, $38,900,000; Yukon Territory, $322,000; and the Northwest Territories, $675,000.

Tables 2 to 9 contain 1964 data for hospitals listed in the federal-provincial hospital insurance agreements. The bulk of the hospitals listed in those agreements are "budget review" hospitals, which are subject to provincial budget-approval. Budget review hospitals include publicly owned general hospitals providing acute or short-term care and special hospitals such as pediatric, maternity, orthopedic,

and chronic hospitals. Also listed in the agreements are "contract" and federal hospitals. Contract hospitals are private and industrial hospitals that provide insured hospital care at a contractually-agreed rate per patient-day. Federal hospitals include veterans' hospitals, Indian hospitals, and many small nursing stations operated by Indian and Northern Health Services.

As shown in Table 2, at the end of 1964 there were 1,313 hospitals listed in the federal-provincial agreements. Table 3 shows that 1,295 of these hospitals submitted reports and had 132,623 beds and cribs set up on December 31, 1964, a rate of 6.9 beds and cribs per thousand population. About 87 per cent of these beds were in budget review hospitals, 5 per cent in contract hospitals, and 8 per cent in federal hospitals. Provincial rates of hospital beds per thousand population ranged from 5.2 beds in Newfoundland to 8.9 in Alberta, and Territorial rates were even higher. In Quebec and in the Atlantic Provinces bed:population ratios were below the national average. In Ontario and British Columbia those ratios were close to the national average while in the remaining provinces they were above the national average.

Table 4 shows that in 1964, patients spent a total of 38,873,442 days in hospitals listed in the federal-provincial agreements, of which 35,280,306 or 90.8 per cent were insured patient-days; there were 2,021.0 patient-days of adults and children per thousand total population and 1,855.7 insured patient-days of adults and children per thousand insured population. The number of insured patient-days per thousand insured population varied from 1,322.4 in Newfoundland to 2,297.0 in Saskatchewan.

Table 5 shows that the average length of stay of patients in budget review general hospitals was 10.2 days and in budget review chronic and convalescent hospitals 147.5 days. In the provinces the average length of stay in budget review general hospitals ranged from 13.4 days in Newfoundland to 8.9 days in Alberta. In budget review chronic and convalescent hospitals the average length of stay ranged from 38.6 days in Nova Scotia to 252.0 days in Saskatchewan. It should be mentioned that the chronic and convalescent length of stay data for patients in the budget review general hospitals that provide this type of care is not tabulated separately but is included in the rest of the length of stay data.

Table 5 also shows that the national average percentage occupancy for budget review general hospitals in 1964 was 80.5 and the corresponding figure for budget review chronic and convalescent hospitals was 87.2. In the provinces the average percentage occupancy in budget review general hospitals ranged from 75.2 in Alberta to 82.5 in Ontario. Variations among the provinces in percentage occupancy are partly due to the size of hospitals; large hospitals have generally higher rates of occupancy than small hospitals.

TABLE 2 - NUMBER OF HOSPITALS AND OTHER FACILITIES LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY STATUS OF HOSPITAL, BY PROVINCE, DECEMBER 31, 1964

Province	Number of hospitals				Number of other facilities(1)	Total number of hospitals and other facilities
	Budget review	Contract	Federal government	Total		
Newfoundland	40	5	1	46	1	47
Prince Edward Island	9	-	-	9	1	10
Nova Scotia	47	-	1	48	2	50
New Brunswick	40	-	2	42	1	43
Quebec	165	94	13	272	2	274
Ontario	216	93	14	323	4	327
Manitoba	81	7	17	105	2	107
Saskatchewan	153	5	4	162	11	173
Alberta	131	25	8	164	7	171
British Columbia	91	14	6	111	1	112
Yukon Territory	2	-	3	5	1	6
Northwest Territories	1	8	17	26	1	27
CANADA	976	251	86	1,313	34	1,347

(1) Includes 18 contract facilities (Red Cross blood depots) and 16 budget review facilities (provincial laboratories, cancer clinics, restoration centres, and nursing stations).

TABLE 3 - NUMBER OF BEDS AND CRIBS SET UP, AND RATE PER 1,000 POPULATION (1), IN REPORTING HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY PROVINCE, AS AT DECEMBER 31, 1964

Province	Number of hospitals reporting	Beds and cribs set up	
		Number	Rate per 1,000 population
Newfoundland	46	2,542	5.2
Prince Edward Island	9	628	5.9
Nova Scotia	48	4,537	6.0
New Brunswick	42	4,131	6.7
Quebec	269	34,469	6.2
Ontario	319	46,390	7.0
Manitoba	104	6,992	7.3
Saskatchewan	156	7,937	8.4
Alberta	160	12,804	8.9
British Columbia	111	11,555	6.6
Yukon Territory	5	152	9.5
Northwest Territories	26	486	19.4
CANADA	1,295	132,623	6.9

(1) Based on 1964 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

TABLE 4 - TOTAL PATIENT-DAYS AND INSURED PATIENT-DAYS (EXCLUDING NEWBORNS' DAYS) IN REPORTING HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, WITH RATES PER 1,000 TOTAL AND INSURED POPULATION, BY PROVINCE, 1964

Province	Number of hospitals reporting	Total patient-days during year		Insured patient-days during year		Insured as a percentage of total patient-days
		Number	Rate(1)	Number	Rate(2)	
Newfoundland	47	696,430	1,418.4	647,959	1,322.4	93.0
Prince Edward Island	9	175,571	1,640.8	166,190	1,567.8	94.7
Nova Scotia	48	1,301,490	1,712.5	1,173,051	1,587.3	90.1
New Brunswick	42	1,204,638	1,952.4	1,066,984	1,752.0	88.6
Quebec	269	10,382,542	1,866.7	9,702,623	1,749.5	93.5
Ontario	319	13,966,164	2,120.6	12,542,986	1,935.0	89.8
Manitoba	104	2,008,904	2,097.0	1,794,648	1,938.7	89.3
Saskatchewan	157	2,250,575	2,386.6	2,135,453	2,297.0	94.9
Alberta	161	3,382,661	2,362.2	3,140,045	2,211.3	92.8
British Columbia	111	3,414,103	1,964.4	2,850,357	1,653.3	83.5
Yukon Territory	5	22,520	1,407.5	18,334	1,222.3	81.4
Northwest Territories	26	67,844	2,713.8	41,676	1,667.0	61.4
CANADA	1,298	38,873,442	2,021.0	35,280,306	1,855.7	90.8

(1) Per 1,000 total population; based on 1964 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

(2) Per 1,000 insured population; based on annual average number of insured persons under provincial plans, 1964.

TABLE 5 - AVERAGE LENGTH OF STAY[1] AND PERCENTAGE OCCUPANCY[2] IN BUDGET REVIEW GENERAL AND CHRONIC AND CONVALESCENT HOSPITALS, BY PROVINCE, 1964

Province	Budget review general hospitals				Budget review chronic and convalescent hospitals		
	Number of hospitals reporting		Average length of stay	Percentage occupancy	Number of hospitals reporting	Average length of stay	Percentage occupancy
	Average length of stay	Percentage occupancy					
Newfoundland	23	40	13.4	79.8	-	-	-
Prince Edward Island	8	8	9.5	76.0	1	-	83.9
Nova Scotia	44	44	10.6	78.6	2	38.6	71.1
New Brunswick	36	36	9.9	80.1	3	43.2	88.5
Quebec	128	128	10.3	81.3	28	122.5	89.7
Ontario	190	190	10.8	82.5	23	184.3	85.9
Manitoba	76	76	9.1	79.9	4	101.3	88.8
Saskatchewan	149	148	9.5	76.5	4	252.0	93.6
Alberta	106	106	8.9	75.2	24	238.2	82.9
British Columbia	86	86	9.4	81.2	-	-	-
Yukon Territory	2	2	6.6	32.6	-	-	-
Northwest Territories	1	1	8.1	49.5	-	-	-
CANADA	849	865	10.2	80.5	89	147.5	87.2

(1) Based on patient-days since admission of patients other than newborn infants separated from hospital during year (discharges and deaths), divided by separations.

(2) Patient-days during year as a percentage of 366 times beds set up on December 31. Excludes bassinets and newborn-days.

In 1964, there were 3,115,218 patients admitted to reporting hospitals listed in hospital insurance agreements (Table 6), a rate of 162.0 admissions per thousand population. Discharges and deaths of patients in those hospitals amounted to 3,112,292, a rate of 161.8 separations per thousand population. The number of admissions per thousand population in the provinces ranged from 119.8 in Newfoundland to 224.3 in Saskatchewan. Similarly, the number of separations per thousand population varied among the provinces from 119.4 in Newfoundland to 224.3 in Saskatchewan.

Table 7 shows that the 1,272 hospitals listed in the federal-provincial agreements, and that reported employment in 1964, employed a total of 218,772 persons on a full-time basis and 25,505 persons on a part-time basis.

Tables 8 and 9 deal with the gross operating costs of budget review hospitals. The gross operating costs or "revenue fund expenditures", which include some cost items that are not sharable under the federal-provincial agreements, amounted in 1964 to $982 million, or $29.23 per patient-day, in budget review hospitals. Provincially per diem costs varied from $22.65 in Prince Edward Island to $32.32 in Quebec. Provincial differences among the per-patient-day costs of budget review hospitals reflect, among others, differences in costs of labour and other items, and differences in the scope and type of hospital services provided in these hospitals. For example, some provinces provide a large proportion of the low per-patient-day cost geriatric and convalescent care in budget review hospitals, while in other provinces the bulk of this type of care is provided outside the budget review hospitals. Inclusion or exclusion of this low per-patient-day cost care in the operating costs of the budget review hospitals affects the total per-patient-day operating costs for those hospitals.

The per capita national average operating cost of budget review hopitals in 1964 amounted to $51.04. Among the provinces the per capita cost varied from $33.63 in Newfoundland to $55.07 in Ontario. In addition to the costs of labour and the types of services provided, which are mentioned above, the varying degree of intensity of utilization of hospital services contributes to variations in the provincial average per capita operating costs in the budget review hospitals. It should be noted that some provinces rely more heavily than others on contract and federal hospitals to provide some types of insured hospital care and this also is reflected in the provincial average per capita operating cost in budget review hospitals.

Hospitals are service-producing institutions and, as such, they use a high proportion of labour. Also, improvement and expansion of hospital services entail changes in the quality of skills and expansion in the number of employees. Table 9

TABLE 6 - ADMISSIONS AND SEPARATIONS DURING YEAR IN REPORTING HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, AND RATES PER 1,000 POPULATION(1), ADULTS AND CHILDREN, BY PROVINCE, 1964

Province	Number of hospitals reporting	Admissions during year		Separations during year	
		Number	Rate per 1,000 population	Number	Rate per 1,000 population
Newfoundland	47	58,835	119.8	58,645	119.4
Prince Edward Island	9	17,372	162.4	17,334	162.0
Nova Scotia	48	114,036	150.0	114,019	150.0
New Brunswick	42	108,213	175.4	108,260	175.5
Quebec	269	788,590	141.8	788,029	141.7
Ontario	319	1,040,030	157.9	1,038,416	157.7
Manitoba	104	176,113	183.8	176,138	183.9
Saskatchewan	157	211,495	224.3	211,481	224.3
Alberta	138	283,880	198.2	283,387	197.9
British Columbia	111	307,190	176.7	307,080	176.7
Yukon Territory	5	2,931	183.2	2,931	183.2
Northwest Territories	26	6,533	261.3	6,572	262.9
CANADA	1,275	3,115,218	162.0	3,112,292	161.8

(1) Based on 1964 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

TABLE 7 - TOTAL PERSONNEL EMPLOYED IN REPORTING HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY PROVINCE, DECEMBER 31, 1964

Province	Number of hospitals reporting	Number of persons employed	
		Full-time	Part-time
Newfoundland	46	4,473	209
Prince Edward Island	9	945	74
Nova Scotia	48	8,245	607
New Brunswick	42	7,552	591
Quebec	269	64,870	5,135
Ontario	319	77,015	12,430
Manitoba	104	11,294	1,685
Saskatchewan	156	11,072	1,189
Alberta	137	16,381	1,569
British Columbia	111	16,410	1,916
Yukon Territory	5	153	9
Northwest Territories	26	362	91
CANADA	1,272	218,772	25,505

TABLE 8 - REVENUE FUND EXPENDITURES OF REPORTING BUDGET REVIEW HOSPITALS, TOTAL, PER PATIENT-DAY(1), AND PER CAPITA(2), BY PROVINCE, 1964

Province	Number of hospitals reporting	Total expenditures	Expenditures per patient-day	Expenditures per capita
Newfoundland	48	$ 16,510,131	$26.20	$33.63
Prince Edward Island	9	3,976,124	22.65	37.16
Nova Scotia	47	34,270,153	29.36	45.09
New Brunswick	40	31,220,584	28.64	50.60
Quebec	165	285,304,571	32.32	51.30
Ontario	216	362,682,132	29.82	55.07
Manitoba	81	45,201,540	25.47	47.18
Saskatchewan	144	50,803,179	25.84	53.87
Alberta	131	72,389,591	24.45	50.55
British Columbia	91	78,878,007	27.98	45.38
Yukon Territory	2	155,875	50.25	9.74
Northwest Territories	1	270,113	33.87	10.80
CANADA	967	$981,662,000	$29.23	$51.04

(1) Patient-days during year for adults and children.

(2) Based on 1964 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

TABLE 9 - REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS, TOTAL, PER PATIENT-DAY, PER CAPITA, AND PERCENTAGE DISTRIBUTION, BY TYPE OF ACCOUNT, CANADA, 1964

Item	Total expenditures	Expenditures per patient-day	Expenditures per capita	Percentage distribution of total expenditures
Departmental expense				
Salaries and wages	634,519,907	18.89	32.99	64.6
Medical and surgical supplies	30,855,715	.92	1.60	3.1
Drugs	37,673,561	1.12	1.96	3.8
Raw food	51,989,367	1.55	2.70	5.3
Other departmental supplies and expense	156,688,241	4.67	8.15	16.0
Total departmental expense	911,726,791	27.15	47.40	92.9
Other (non-departmental) revenue fund expense	69,935,209	2.08	3.64	7.1
Total revenue fund expense	981,662,000	29.23	51.04	100.0

(1) Based on 1964 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

shows that salaries and wages account for almost two-thirds of the revenue fund expenditures in the budget review hospitals. This item of expenditure, apart from being the largest, is also increasing at the fastest rate, reflecting the growing staff-patient ratios, the increase in costs per unit of work, and the need for both better qualified and more numerous staff to service the increasing population of Canada.

Table 10 deals with hospital utilization by age and sex and Table 11 relates to hospital utilization by class of disease. Much additional information can be found in the annual reports of the provincial hospital insurance plans.

Subsection 5 - Dominion Council of Health

The Dominion Council of Health is the principal advisory agency to the Minister of National Health and Welfare on federal-provincial health matters. Its membership includes the Deputy Minister of National Health, who acts as chairman, the chief health officer of each province, and five appointees of the Governor-in-Council representing the universities, labour, agriculture, and organizations of French and English-speaking women. The Council meets semi-annually. Federal-provincial technical advisory committees of the Council deal with specific aspects of public health.

Section 3 - Provincial and Local Health Services

Provincial and local health services may be grouped into several broad categories: provincial preventive public health services; local preventive public health services; services for specific diseases or disabilities, combining prevention and treatment; services related to general medical and hospital care; and services for disabled and chronically ill persons.

Provincial and local governments co-operate closely in providing community public health services. The autonomy of the provinces and their social, economic, and geographic diversity make for some variety in legislative provisions, in financial arrangements, and in the detailed division of functions between provincial health departments and local and voluntary agencies. Each province, however, offers all or nearly all of a basic range of public health services that includes environmental health, occupational health, communicable disease control, maternal and child health, dental health, nutrition, health education, and public health laboratories.

TABLE 13 - HOSPITALIZATION, BY AGE AND SEX, FOR IN-PATIENTS(1) INSURED BY PROVINCIAL HOSPITAL INSURANCE PLANS, 1964

	0-4(1)	5-14	15-24	25-44	45-59	60-64	65-74	75+	Age Unknown	Total
PARATIONS										
Male	213,352	187,838	118,868	219,859	201,041	67,556	119,109	99,759	1,254	1,228,636
Female	158,971	163,197	383,640	666,215	225,184	59,752	110,754	95,858	1,754	1,865,325
Total	372,323	351,035	502,508	886,074	426,225	127,308	229,863	195,617	3,008	3,093,961
PARATIONS PER 000 POPULATION										
Male	182.7	87.7	78.2	89.5	143.4	216.6	271.7	384.6	-	126.7
Female	142.5	78.8	253.8	272.9	164.2	192.2	234.4	322.2	-	195.6
Total	163.0	83.9	167.3	180.9	153.7	204.4	252.3	351.3	-	160.9
TIENT-DAYS NCE ADMISSION										
Male	1,751,813	1,146,422	984,618	2,372,758	2,971,859	1,237,170	2,622,627	3,082,537	14,194	16,183,988
Female	1,333,159	953,894	2,440,633	5,286,594	3,275,442	1,133,698	2,696,165	3,945,061	19,413	21,084,059
Total	3,084,972	2,100,316	3,425,251	7,659,352	6,247,301	2,370,868	5,318,792	7,027,618	33,607	37,268,047
YS SINCE ADMISSION R 1,000 POPULATION										
Male	1,500.0	535.5	647.3	965.7	2,119.6	3,966.6	5,982.3	11,883.3	-	1,668.7
Female	1,194.9	466.5	1,646.5	2,165.3	2,388.2	3,646.5	5,705.0	13,260.8	-	2,210.9
Total	1,358.9	501.8	1,140.5	1,563.6	2,252.4	3,806.8	5,838.4	12,619.2	-	1,937.5
ERAGE STAY OF PARATIONS										
Male	8.2	6.1	8.3	10.8	14.8	18.3	22.0	30.9	11.3	13.2
Female	8.4	5.8	6.4	7.9	14.5	19.0	24.3	41.2	11.1	11.3
Total	8.3	6.0	6.8	8.6	14.7	18.6	23.1	35.9	11.2	12.0
PULATION (In Thousands)										
Male	1,167.9	2,140.7	1,521.0	2,457.0	1,402.1	311.9	438.4	259.4	-	9,698.4
Female	1,115.7	2,044.6	1,482.3	2,441.5	1,371.5	310.9	472.6	297.5	-	9,536.6
Total	2,283.6	4,185.3	3,003.3	4,898.5	2,773.6	622.8	911.0	556.9	-	19,235.0

Excludes newborns.

Source: Data supplied to Department of National Health and Welfare by Provincial Plans.

TABLE 11 - HOSPITALIZATION, BY CLASS OF DISEASE, OF IN-PATIENTS[1] INSURED BY PROVINCIAL HOSPITAL INSURANCE PLANS,[2] 1964

Class of disease[3]	Separations		Days of care for separations		Average stay of separations	Percentage distribution	
	Total	Per 1,000 population	Total	Per 1,000 population		Separations	Days of care
All diseases	3,074,267	159.8	36,869,080	1,916.8	12.0	100.0	100.0
I. Infective and parasitic diseases	43,624	2.3	615,626	32.0	14.1	1.4	1.7
II. Neoplasms	165,867	8.6	3,187,484	165.7	19.2	5.4	8.6
III. Allergic, endocrine system, metabolic and nutritional diseases	86,834	4.5	1,408,804	73.2	16.2	2.8	3.8
IV. Diseases of the blood and blood-forming organs	17,403	0.9	263,037	13.7	15.1	0.6	0.7
V. Mental, psychoneurotic, and personality disorders	84,208	4.4	1,561,524	81.2	18.5	2.7	4.2
VI. Diseases of the nervous system and sense organs	148,699	7.7	4,100,623	213.2	27.6	4.8	11.1
VII. Diseases of the circulatory system	243,297	12.6	5,411,556	281.3	22.2	7.9	14.7
VIII. Diseases of the respiratory system	474,097	24.6	3,106,732	161.5	6.6	15.4	8.4
IX. Diseases of the digestive system	414,223	21.5	4,289,031	223.0	10.4	13.5	11.6
X. Diseases of the genito-urinary system	246,148	12.8	2,415,425	125.6	9.8	8.0	6.6
XI. Deliveries and complications of pregnancy, childbirth and the puerperium	595,715	31.0	3,405,644	177.1	5.7	19.4	9.2
XII. Diseases of the skin and cellular tissue	62,784	3.3	619,671	32.2	9.9	2.0	1.7
XIII. Diseases of bones and organs of movement	105,887	5.5	2,118,420	110.1	20.1	3.4	5.7
XIV. Congenital malformations	30,224	1.6	459,419	23.9	15.2	1.0	1.2
XV. Certain diseases of early infancy	11,844	0.6	158,267	8.2	13.4	0.4	0.4
XVI. Symptoms, senility, and ill-defined conditions	71,991	3.7	595,028	30.9	8.3	2.3	1.6
XVII. Accidents, poisonings, and violence	271,222	14.1	3,152,789	163.9	11.6	8.8	8.6

(1) Excludes newborn.

(2) Newfoundland, Prince Edward Island, and Manitoba also include non-insured residents of the province; Quebec and Ontario include both resident and non-resident non-insured in-patients; Alberta includes insured resident in-patients and 6,438 non-insured residents.

(3) According to "International Statistical Classification of Diseases, Injuries and Causes of Death, 1955."

Source: Data supplied by the provinces to the Department of National Health and Welfare.

Subsection 1 - Provincial Preventive Public Health Services

Environmental health. - The control of factors in the environment that are harmful to physical health is a rapidly expanding area of public health activity. Much of the work in community sanitation involves traditional inspection duties essential to the maintenance of pure milk, water, and food supplies, sewage disposal systems, and sanitary conditions in public areas. Increasing industrialization and urbanization, however, have both magnified the old problems and imposed new responsibilities. Air pollution, water pollution, radiation exposure, and the use of pesticides are emerging as major environmental problems, necessitating the co-operative efforts of governments and other agencies in research and in planning effective control measures.

Occupational health. - Services designed to prevent accidents and occupational diseases and to maintain the health of employees are the common concern of provincial health departments, labour departments, workmen's compensation boards, and industry management. Provincial agencies regulate working conditions and offer consultant and educational services to industry. All provinces have legislation (Factory Acts, Shop Acts, Mines Acts, Workmen's Compensation Acts) setting health safety standards for employment.

Communicable disease control. - There are separate divisions of epidemiology or communicable disease control in six provinces; in the other provinces these functions are handled by other provincial medical consultants. Local health authorities undertake casefinding and diagnostic services in co-operation with public health laboratories, carry out epidemiological investigations, and often participate in tuberculosis and venereal disease control measures. All provincial health departments organize immunization programs for the public against diphtheria, tetanus, poliomyelitis, whooping cough, and smallpox. Through agreement with the federal government, live oral poliovirus vaccine (Sabin) as well as Salk vaccine is made available by provincial health departments for immunization against poliomyelitis. Other agents such as gamma globulin may be provided under certain conditions for protection against measles and infectious hepatitis.

Maternal and child health. - Most provincial health departments have Maternal and Child Health Divisions under medical direction or have made other administrative arrangements to provide consultant services in this field. In addition, six of the provinces have consultant nursing services within these divisions. Provincial divisions provide advisory services to local health departments and to hospitals, conduct studies of local problems and needs, and assist in the training of health personnel.

Dental health. - All provincial health departments have dental health divisions that administer programs varying under local conditions but directed almost entirely to health education and the care of children. Training of dentists and dental hygienists in public health, the operation of children's preventive and treatment clinics, and health education are primary concerns in all provinces. Water fluoridation projects involving 4,324,000 people are in operation in eight provinces and in the Northwest Territories. Four provinces -- Alberta, Manitoba, Ontario, and Nova Scotia -- have set up, in conjunction with their dental schools, special courses for dental hygienists. In all ten provinces clinical care is provided for children in remote rural areas. A locally-sponsored plan in which the cost of dental services for children is shared by the community and the provincial health department is in operation in more than 90 communities in British Columbia.

Nutrition. - Services include technical guidance, education, consultation, and research. In some provinces, school lunch programs are sponsored and dietary supplements distributed. Five provinces have special nutrition divisions; in other provinces, consultants in nutrition function under a broader grouping of departmental services.

Health education. - A basic concern of provincial health authorities is to stimulate public interest in important health needs, and in most provincial health departments a Division of Health Education is established for this purpose, directed by a professional full-time 'health educator'. The division may also provide consultative services to the management of the Department, to local authorities, and to voluntary associations.

Public health laboratories. - The public health laboratory was one of the earliest provincial services developed to assist local public health departments in the protection of community health and the control of infectious diseases. Public health bacteriology (testing of milk, water, and food), diagnostic bacteriology, and pathology are the principal functions of the laboratory service, with medical testing for physicians and hospitals steadily increasing in volume. Efforts to co-ordinate public health and hospital laboratory services and measures to bring laboratory facilities to rural areas are among the recent developments.

Subsection 2 - Local Preventive Public Health Services

Local health authorities are responsible generally for the administration and enforcement of local regulations and by-laws relating to health and for the direct provision of various preventive public health services. The scope of

preventive services varies greatly in different areas and provinces, but basic programs are similar, covering environmental sanitation, communicable disease control, child, maternal, and school health, health education, and vital statistics. Vital statistics are collected locally and information is used to analyse and plan public health activities. Among other services provided locally by some health units or departments are mental health, occupational health, community nutrition, and preventive dental health. Increasing attention is being directed towards measures designed to control the chronic diseases, to extend the period of active life, and to provide adequate public health protection for the aging segment of the population.

Health units. - Full-time local public health services under the direction of full-time medical health officers have been developed partly through municipal health departments, partly through joint provincial-local health units, and partly through provincial health districts. City health departments are administered and financed directly by the municipality concerned, usually through a municipal board of health. Local health units are designed primarily for rural areas with staff serving county or other combinations of local government jurisdictions, and financial and administrative responsibility shared between provincial and local authorities; while the division of responsibility varies among provinces, the trend is toward an increasing degree of provincial control. In some provinces (mainly in the Atlantic Provinces) provincially administered local health districts provide services without administrative participation by local citizens.

At the end of 1965, full-time local public health services were supplied through 34 urban health departments covering 6.4 million persons and 190 local health units covering 10.7 million persons. The total number of full-time health departments, units, and districts had increased to 224 in 1965 from 157 in 1948. The basic staff of an urban health department or local health unit usually comprises a medical officer of health, some public health nurses, and sanitary inspectors. To a great extent the services provided depend upon having a sufficient number of qualified persons employed by the agency. Total full-time staff employed by local agencies at the end of 1965 numbered 5,896, of which 2,674 were in urban health departments and 3,222 were employed by local health units. Many areas not requiring full-time services of health personnel employ part-time personnel but more often these services are provided directly to the local area by the provincial health department. In addition, provinces are responsible for providing local health services in municipally unorganized territories.

Subsection 3 - Services for Specific Diseases or Disabilities

Mental health. - Treatment programs for the mentally ill have centered mainly around three types of facilities: the mental hospital, the psychiatric unit in the general hospital, and the organized community mental health clinic. These facilities, however, no longer have separate and distinct functions. New emphasis on the role of the community and its resources in the treatment and rehabilitation of the mentally ill is affecting the whole program of in-patient care. Utilizing the basic clinical facilities of general hospitals and mental hospitals the community program is extending its scope and usefulness through the provision of day-care centres, sheltered workshops, half-way houses, and foster home and boarding home care. Most of the large general hospitals in Canada have organized psychiatric units providing bed accommodation for short-stay patients. Further planning in community-based services concerns the development of small regional psychiatric hospitals from which a comprehensive community program will emanate. Examples of this type are the 150-bed hospital in Yorkton, Saskatchewan, a 68-bed psychiatric hospital in Selkirk, Manitoba, the development community facilities for in-patient, out-patient, and day care in several Ontario cities, for example, Ottawa, Sudbury, and Windsor. The Atlantic Provinces, Quebec, and the Western Provinces are all developing new facilities and strenghtening existing ones.

Special centres for the assessment and diagnostic evaluation of mentally retarded children are also being developed. Day-training schools or classes for the trainable retarded, sponsored by local Associations of parent groups forming the Canadian Association for Retarded Children, are now organized throughout the land. Research programs designed to afford better understanding and management of mental retardation problems are being developed and expanded in all provinces.

Most public mental hospitals provide care and treatment for all types of mental illness. New programs of recreational and industrial therapy and enlarged and modernized clinical and surgical facilities are examples of widespread improvements in mental hospital care that particularly benefit patients undergoing active treatment. More recently, planning has been undertaken to reassess the status of the long-term chronically ill patient. Since 1961 new legislation governing the admission and care of the mentally ill has been enacted in six provinces - Ontario, Nova Scotia, Saskatchewan, Alberta, British Columbia, and Manitoba - designed to promote easier and more informal methods of admission and discharge and to establish machinery guaranteeing periodic review of the medical certification of long-term patients.

A great part of the cost of care in mental hospitals is borne by the provincial governments, although a charge, according to ability to contribute, may be made in some provinces. Newfoundland and Saskatchewan provide complete free care; Manitoba covers minimum maintenance costs for all patients; in Nova Scotia the provincial hospital gives free care to patients requiring active treatment; and in Ontario mental-institution treatment is included in the hospital care insurance plan.

Tuberculosis. - The fight against tuberculosis is one of the major programs of all health departments. Free hospitalization and free drug treatment, both on an in-patient and a domiciliary basis, is provided. In two provinces extensive BCG programs are in effect and in the other provinces this prophylactic is provided to groups at special risk. Case-finding programs in the form of community tuberculin and X-ray surveys, surveys of high risk groups, and the follow-up of all arrested tuberculosis cases are routine. These activities have resulted in a decline in the Canadian tuberculosis death rate of 85 per cent since 1951. In 1965 the rate was 3.6 per 100,000 population. The number of beds set up in public sanatoria declined from a peak of 18,977 in 1953 to 6,298 in 1964.

Cancer. - Health departments and lay and professional groups working for the control of cancer have been concerned mainly with four aspects of problem--diagnosis, treatment, research, and public education. In cancer detection and treatment, specialized medicine, hospital services, and an expanding public health program are closely related. There are programs operating under health departments in four provinces; four others have provincially supported cancer agencies or commissions. These sponsor the work of diagnosis and treatment in special clinics, located usually within the larger general hospitals. Under all the provincial hospital insurance plans, the benefits pertaining to in-patient care in the treatment of cancer are essentially similar and include such special services as diagnostic radiology, laboratory tests, and radiotherapy. Similar services for out-patients are covered either by hospital insurance or by federal-provincial Cancer Control grants. Comprehensive free medical programs for cancer patients are in operation in Saskatchewan and Alberta and for cancer in-patients in New Brunswick.

Venereal disease. - Free diagnostic and treatment services are available in all provinces but the operation of government clinics is being increasingly superseded by the method of supplying free drugs to private physicians who are reimbursed for treatment of indigents on a fee-for-service basis.

Alcoholism. - Ontario, Manitoba, Alberta, and British Columbia carry out research and education programs and operate centres for treatment, supported largely by public funds. Ontario, Saskatchewan, and Alberta also have rehabilitation programs for alcoholic inmates of reform institutions. Legislation in Newfoundland, New Brunswick, Nova Scotia, and Quebec authorizes the setting up of similar agencies to initiate research and education studies in those provinces.

Other diseases or disabilities. - Services for persons with chronic disabilities, such as heart disease, arthritis, diabetes, visual and auditory impairment, and paraplegia have been developed largely by voluntary agencies assisted by federal and provincial funds. A brief description of the programs of some of these agencies is given in Part IV, commencing on page 111, which deals with national voluntary health and welfare activities, and in the subsection on Services for the Disabled and Chronically Ill starting at page 48.

Subsection 4 - Public Medical Care Programs

Province-wide medical care insurance programs are operating in Saskatchewan, Alberta, British Columbia, Ontario, and Newfoundland, with differences in degree and extent of coverage, and the benefits provided. In addition, most of the provinces have programs for public assistance recipients. In the present context, public medical care can be grouped into several broad categories: provincial universal-coverage medical care program; provincially sponsored or assisted medical care programs; provincial programs for public assistance recipients; and provincial medical care program for other selected groups.

Provincial Universal-Coverage Compulsory Medical Care Program:

Saskatchewan Medical Care Insurance Plan - Only one province, i.e., Saskatchewan has a universal coverage medical care program. Since July 1962, every person who has resided in Saskatchewan for three months (and is not entitled to receive medical services under other public programs) and has paid, or has had paid on his behalf, the required premiums, is entitled to have payment made on his behalf from the Medical Care Insurance Fund for medical, surgical, and obstetrical care, without limit, in his home, in the doctor's office, and in hospital, from his physician-of-choice (including payment at specialists' rates for referred specialists' services). The insured services include:

Medical Care - the diagnosis and treatment of all medical disabilities and conditions.

Surgery - surgical procedures, including diagnosis, pre-operative and postoperative care, and, when required, the services of a surgical assistant.

Obstetrics - care of the mother during pregnancy, delivery, and the postnatal period.

Specialist's services - insured at specialist's rates when the beneficiary is referred by another physician; at general practitioner's rates when not so referred, except that if the service is within the specialist's field of practice and is one for which the Schedule of Fees of the College of Physicians and Surgeons lists only a "Specialist Fee", the payment is calculated at the specialist's rate even if the beneficiary was not referred to the specialist by another physician.

Anaesthesia - the administration of anaesthesia in conjunction with diagnostic, surgical, obstetrical, dental, and other procedures that are otherwise insured.

Laboratory - all laboratory services, including interpretations, performed by a specialist in pathology in a non-hospital facility; also, a restricted list of laboratory services performed, in their offices, by physicians who are not pathologists.

Radiology - X-ray services, including interpretations, performed by a specialist in radiology in a non-hospital facility.

Preventive medicine - inoculations and vaccinations where not provided through any government agency, and routine physical examinations when not for the purpose of marriage, employment, insurance, nor at the request of any third party.

Dentistry - where performed by a dentist in support of a surgeon performing maxillo-facial surgery.

All services insured in Saskatchewan are also insured when provided outside the province. Payment for out-of-province benefits is limited to the rates payable within the province, and is made to the beneficiary on a reimbursement basis.

Plastic surgery for cosmetic purposes, refractions, appliances, dentistry except as specified above, drugs, and special duty nurse and ambulance service are excluded from the program, as normally are services already provided under other provincial and federal legislation, such as the Mental Health Act, the Cancer Control Act, and the Venereal Disease Prevention Act, and the Federal National Defence Act and Veterans Rehabilitation Act. Physiotherapy, formerly a benefit, has been excluded from the program since July 1, 1965.

There are no restrictions relating to age or pre-existing conditions.

Physicians may elect to receive payment in a number of ways; usually either they choose to receive direct payment from the Medical Care Insurance Commission at 85 per cent of the 1959 Schedule of Minimum Fees of the College of Physicians and Surgeons of Saskatchewan (as amended) as payment in full, or their patients enrol voluntarily with an approved health agency, which pays the physician an amount equal to the amount paid to the agency by the Commission in respect of the physician's assessed account.

Alternatively, they may contract for a salary or similar arrangement.

Finally, where the patient (or the doctor) is not a member of an approved health agency (or they are not members of the same one) and the doctor chooses not to bill the Commission directly, he may submit his bill to the patient. If the bill is itemized, the patient may submit it to the Commission and receive payment for insured services at 85 per cent of the assessed fee. The doctor may charge the patient an amount over-and-above what the patient receives from the Commission. If, however, the doctor refuses to provide the patient with an itemized bill, the Commission will not pay any portion of the account.

The Saskatchewan program is financed almost wholly from personal premiums plus general revenue contributions. In 1965, premiums accounted for 25 per cent and general revenue contributions for 73 per cent of the Commission's total receipts. There were more than 887,000 persons covered by the Saskatchewan Medical Care Insurance Act at the end of June 1965 or about 93 per cent of the provincial population. Most of those not covered were protected under other public programs, federal or provincial.

Certain classes of residents are eligible for services but are exempt from premium payment; others are exempted from the premium and are also ineligible for the insured services.

Indians who live on reserves, or who have lived apart from reserves for less than 12 months, neither pay premiums nor receive benefits (negotiations with the federal government to include them as beneficiaries were continuing as of May 1966; meanwhile they receive medical care under existing contractual arrangments with individual physicians). Members of the Armed Forces and the Royal Canadian Mounted Police and recipients of War Veterans' Allowances are also exempt from premiums and ineligible for benefits. However, their spouses

and dependents, if resident in Saskatchewan, are eligible for coverage, and premiums are required to be paid on their behalf. Patients in mental hospitals and tuberculosis sanatoria and inmates of penitentiaries and provincial jails are not required to pay premiums. Recipients of federal Old Age Security and Blind Pensions who qualify for the Saskatchewan supplemental allowances, Aid-to-Dependent-Families recipients, and provincial government wards receive physicians' services under the program and continue to receive other coverage as part of the health services provided under the existing program for recipients of public assistance. Recipients of Old Age Assistance (65-68 age-group) have their medical care insurance premiums paid by the province. Recipients of municipal social aid normally have their medical care insurance premiums paid on their behalf by the municipality they live in.

The Swift Current Health Region - The former municipal-doctor plans in Saskatchewan were discontinued in July 1962, but special arrangements were made to continue, under local auspices, insured medical services for some 54,000 residents of the Swift Current Health Region, which had operated a prepaid medical-dental program since 1946. Under the agreement between the Region and the Commission, payment for all insured services for beneficiaries in the region is made by the Region Board (the executive body) through its contracts with the Swift Current and District Medical Society and individual physicians.

Region residents are exempt from paying provincial medical care premiums and the Board has the authority to levy its own premium (tax) for medical care. The Commission pays to the region a per capita grant based on the per capita cost of medical care insurance in the province outside the Swift Current Health Region, less per capita premium revenue, so providing the region with an income related to the amount spent elsewhere in the province. Any balance required is raised by personal tax levy on residents of the region.

As requested by the Region Board, the contract specifically permits the continuation of utilization fees in the region that are not in effect elsewhere. The Board may no longer, however, levy property taxes for support of medical care services. The Board continues to provide a salaried radiological service, and a dental program emphasizing prevention for children under 12 years of age.

Utilization and Costs - The following statistics relate to the calendar year 1965, and exclude the Swift Current Health Region.

A total of 569,867 residents received benefits of $20,151,300 during the year. Of this amount $13,095,843 was paid through approved health agencies, $5,155,625 paid directly to physicians, and $1,664,406 directly to patients.

The per beneficiary payment for insured services, excluding administrative costs, was $24.42. The cost of administration for 1965 was $1.46 per beneficiary.

Payment for one or more services was made to 569,867 individual beneficiaries, comprising 68 per cent of the covered population. Of families covered, 83 per cent received one or more services. For the families receiving benefits the average payment was $76.

About 56 per cent of families receiving benefits actually received benefits of $50 or less; nearly 20 per cent, $50 to $100; and nearly 16 per cent, $100 to $200. Payment on behalf of 8 per cent of families ranged from $200 to $500, and, for less than one per cent, exceeded $500.

Of the 932 Saskatchewan physicians who provided at least one service for which the Commission made payment, 675 were general practitioners and 257 specialists.

Of the 4,102,200 individual services for which payment was made, 21.7 per cent were provided by specialists and 78.3 per cent by general practitioners. Payments to specialists amounted to 37.4 per cent of the total and payments to general practitioners, to 62.6 per cent. The overall average payment per service was $4.74 for male patients and $5.05 for female patients.

Age groups having the highest incidence of service were infants under 1 year and persons over 65, although the average payments per service in these age groups were below the average.

Children 5 - 14 received fewer services per capita than any other tabulated age group. The services provided to women in the 25-44 age group had the highest unit cost, at $6.23 per service (compared with $5.10 for males in this age group).

Forty-three per cent of all services were initial or repeat office visits. Another 24 per cent were hospital visits and an additional 6 per cent home and emergency calls. Altogether, home, office, and hospital visits represented 73 per cent of all services and 48 per cent of insurance payments. Diagnostic and laboratory tests accounted for 16 per cent of all services and 5 per cent of payments.

General practitioners made 85 per cent of home, office, and hospital calls and specialists 15 per cent. Surgical procedures made up 4 per cent of all services but accounted for 27 per cent of payments. General practitioners provided 71 per cent of surgical services and specialists 29 per cent. Payments for surgery, however, were divided 53 per cent to specialists and 47 per cent to general practitioners.

Provincially Sponsored or Assisted Medical Care Programs:

Three provinces, Alberta, British Columbia, and Ontario, have established provincially assisted voluntary medical care programs.

The Alberta Medical Plan and the Alberta Health Program - The Alberta Medical Plan became effective October 1, 1963. It is designed to help residents with low incomes who voluntarily purchase medical care insurance from approved non-profit and commercial agencies. The approved carriers must make available to all residents a program of insurance that provides the attendance of physicians in home, office, or hospital, as well as surgical, specialist and general diagnostic services, and 20 per cent of the cost of laboratory, radiological and diagnostic services at hospitals, private clinics, and laboratories (the rest being provided under the provincial hospital insurance plan). There must be no exclusions because of age, pre-existing health conditions, or the previous cancellation of a policy with another agency because of abuse. The policy must be guaranteed renewable, and must provide a specified "basic benefit" package of comprehensive medical-care services. It must provide either first-dollar coverage, or a deductible of $25 per person ($50 maximum for a family) with a twenty per cent co-insurance provision.

Maximum premium rates, set by the province, must not be exceeded. For first-dollar coverage, these are $63 for a single person, $126 for a family of two persons, and $159 for a family of three or more persons. For contracts with deductible and co-insurance features, maximum premiums are $42, $84, and $114, respectively.

The plan is financed completely from personal premiums but there is provision for government subsidization of the premium costs of low-income persons. The subsidies are 80 per cent of the premium for persons with no taxable income, 50 per cent for persons with taxable income from $1 to $500, and 25 per cent for persons with taxable income from $501 to $1,000. All residents may insure for medical services either through the doctor-sponsored Medical Services (Alberta) Incorporated or through approved commercial agencies; doctors are reimbursed at 90 per cent of their assessed fees by the former or at 100

per cent by the latter. In October 1965, an estimated 850,000 persons were covered by the Alberta Medical Plan, 59 per cent of the provincial population. Of these, about 187,000, 13 per cent of the provincial population, were covered by subsidized insurance contracts.

Certain benefits are provided subject to waiting periods. Treatment of psychiatric conditions is not available under a non-group contract until the patient has been insured for 12 months, and routine health examinations are not available under any contract until 24 months after the effective date of the contract or until 12 months after the last examination. Obstetrical coverage is limited to cases in which conception postdated the start of the contract. Furthermore, a waiting period of three months during which no benefits are available commences on the date application for insurance is made and the first premium paid; the end of this waiting period is the effective date of the contract. Among services specifically excluded from the Program are sterilization for reasons other than of health, glasses, and dental care.

A doctor is paid either his charged fee or the fee listed in the most recent schedule of fees published by the College of Physicians and Surgeons of Alberta, whichever is lesser. However, a doctor having an agreement with the doctor-sponsored Medical Services (Alberta) Incorporated, who treats a patient insured by MS(A)I, agrees to accept 90 per cent of the schedule-fee as payment in full, unless there is pre-arrangement with the patient for extra-billing.

Several special agencies were established by regulation under the Act setting up the Alberta Medical Plan.

A Co-ordinating Directorate, consisting of one representative each of the Minister of Health, the Alberta College of Physicians and Surgeons, the Canadian Health Insurance Association, and Medical Services (Alberta) Incorporated, under the chairmanship of the representative of the Minister, is in charge of general regulation of the Plan and of making recommendations to the Minister concerning matters such as approval of carriers and legislative changes in the Plan.

An assessment Committee, composed of one representative of the commercial insurance companies, one of MS(A)I, and three representatives of the College of Physicians and Surgeons, was set up to mediate problems arising between physicians and approved carriers.

A non-profit organization, Alberta Medical Carriers Incorporated (A.M.C.I.), to which every approved carrier must belong, was established to operate the pooling arrangements, required under the Plan, for persons 65 and over and extra-risk cases under 65.

Under normal circumstances every approved carrier must participate in the pooling arrangements, whereby all carriers share in the added financial cost of insuring persons with poor health records. A.M.C.I., with the approval of the Co-ordinating Directorate, may change the maximum premium levels from time to time.

Since July 1, 1966 the Alberta Health Program has been in effect. This program comprises the Alberta Medical Plan and a new Extended Health Benefits Plan. The latter makes available, through approved companies and with premium-subsidy rates equal to those under the Alberta Medical Plan, insurance for many additional health services not covered by the Alberta Medical Plan, including prescribed drugs, optometry, physiotherapy, psychology, ambulance, osteopathy, chiropractic, podiatry, naturopathy, and various medical supplies and appliances. A deductible amount, and a co-insurance charge or limited liability on some services, apply to the new Plan.

The British Columbia Medical Plan - The British Columbia Plan took effect September 1, 1965. The Plan, an agency directed by representatives of the government and the medical profession, makes available to all provincial residents insurance that provides most physician's services, as well as limited physiotherapy, special nursing, chiropractic, and naturopathic services. To persons resident in the province for the preceding twelve months, the government offers subsidies of 90 per cent of the premium for persons with no taxable income, and of 50 per cent of the premium for persons with taxable income from $1 to $1,000. Annual premiums are $60 for a single person, $120 for a family of two, and $150 for a family of three or more persons. The government pays two million dollars annually to a Medical Grant Stabilization Fund in order to cover any deficit. In February 1966, over 198,000 persons were covered under the Plan, and 67 per cent of the insurance contracts were subsidized.

Physicians are paid under the program a minimum of 90 per cent of the fees listed in the current schedule, revised biennially, of the provincial College of Physicians and Surgeons. The schedule will be revised according to an agreed-upon formula that takes into account movements in the industrial composite index of average weekly wages and salaries in British Columbia and the consumer price index for Vancouver.

The Plan is administered by a six-member board of directors. Board members are appointed by the government, three upon the recommendation of the Provincial Secretary and three upon the recommendation of the British Columbia Medical Association. One of the directors is appointed president by the government; he has a second deciding vote in case of a tied vote.

The Ontario Medical Services Insurance Plan - The Ontario Medical Services Insurance Plan began paying benefits July 1, 1966. The Plan offers to all Ontario residents an insurance plan that covers most physicians' services.

Subsidies are available to certain persons resident in the province for the previous twelve months. The government will pay the full premium of applicants who had no taxable income during the preceding year, and of recipients of public assistance. It will pay 50 per cent of the premium for single applicants who had taxable income in the preceding year of $500 or less; 50 per cent of the premium for married applicants with one dependent, whose taxable income in the preceding year was $1,000 or less; and 60 per cent ($90) of the premium for married applicants with two or more dependents, whose taxable income was $1,300 or less. Premiums have been set at $60 for a single person, $120 for a family of two, and $150 for a family of three or more. Persons who are unable to continue to pay their medical insurance premium because of unemployment, illness or disability may apply to the Ontario Medical Services Insurance Council for temporary assistance towards continuing their OMSIP coverage.

The Plan makes payments for insured services provided to covered persons at 90 per cent of the schedule of fees of the Ontario Medical Association.

The Plan is administered by the Medical Services Insurance Division of the Ontario Department of Health. A seven-member Medical Services Insurance Council is appointed by the government to advise the Minister of Health on the Plan. Five of its members are drawn from the public at large and two are representatives of the medical profession nominated by the Ontario Medical Association. The Council may make recommendations to the Minister on any matter related to OMSIP. It is specifically charged with making recommendations regarding, (1) premium rates, (2) open enrolment periods, (3) the form and content of the medical insurance contract, (4) the granting of temporary assistance to persons unable to meet their premium payments due to unemployment, illness or disability, (5) the method of payment of physicians when the allowance based on the schedule of fees of the Ontario Medical Association is considered by the Council to be not proper or equitable. In addition the Council deals with complaints related to the Plan and hears appeals arising from the judgements of the Medical Services Insurance Division.

Programs For Public Assistance Recipients:

For several years Nova Scotia, Ontario, Saskatchewan, Alberta, British Columbia and Manitoba have operated programs providing certain personal health care services for specified categories of welfare recipients. Quebec commenced a program in 1966 providing comprehensive physicians' services to recipients of public assistance. Medical care benefits for recipients of assistance in Saskatchewan and Ontario are now administered through the public medical care schemes set up in those provinces.

Coverage extends to virtually all recipients of provincial aid in British Columbia, Alberta, Saskatchewan, Ontario and Quebec. These include persons receiving needs-tested supplements to old age security pensions (a special means test for health care enrolment is used in Ontario), recipients of old age assistance, mothers' allowances and their dependents, disabled persons' allowances, blindness allowances, general welfare assistance and in some provinces child wards, vocational rehabilitation recipients and short term welfare recipients. Manitoba covers aged and infirm persons requiring custodial care, recipients of blind persons' allowances, recipients of mothers' allowances, and their dependents. Nova Scotia enrols only blindness allowance recipients and mothers' allowance recipients and their dependents.

Comprehensive physicians' services including medical attendance in the home, office and hospital, major and minor surgery, diagnostic services and obstetrical care are provided under all of these provincial programs. Some limitations on billing for certain physicians' services such as surgery and hospital visits exist in Nova Scotia.

Dental care and optical care benefits are provided to all covered recipients in the four westernmost provinces, sometimes only on special authorization and/or with dollar limits. Ontario finances a program of dental care for the children of mothers' allowance recipients. Other services that are provided in some provinces include orthopaedic appliances, physiotherapy, chiropody, chiropractic treatment, home nursing and transportation for medical reasons.

Recipients of public assistance in Newfoundland who are individually certified by the welfare officer in their area as being unable to meet their medical care payments can be given free service. Benefits for persons so certified include comprehensive medical services, out-patient drugs and dressings, prosthetic appliances, transportation to and from the hospital, dental care where available, and eye refractions and glasses.

Provincial Medical Care Programs for Other Selected Groups:

Under the Cottage Hospital Medical Care Plan, in about 18 rural cottage hospital districts, Newfoundland pays for subscribers' medical care in the home, doctor's office, and out-patient clinic or cottage hospital, as well as specialist care not available in the local area that is secured in St. John's, Grand Falls or Corner Brook upon referral by the local doctor or nurse. Premiums charged to subscribers vary according to district from $6 to $24 for a family, and from $3 to $12 for a single person. Physicians in cottage hospital districts are paid a full-time negotiated salary, the amount varying with size of district, level of responsibility, years of experience and other factors. In 1964, about 205,000 persons were eligible under the program, some 42 per cent of the provincial population. In three additional rural areas the government subsidizes the costs of voluntary organizations that employ doctors and provide comprehensive services to area residents upon payment of a premium of $10 for a family or $5 for a single person. These plans cover 51,000 persons, or 10 per cent of the population.

Newfoundland also has a partially universal program, the Children's Health Service, financed out of general revenues, which automatically covers all children under sixteen years of age for in-hospital medical and surgical care, anaesthesia and special consultations. The Plan does not cover doctors' bills for home or office calls, nor does it cover the cost of dental services. Physicians are paid for services rendered approximately 80 per cent of the fees of the Newfoundland division of the Canadian Medical Association. The Children's Health Service covers 218,000 children, but of these some 113,000 reside in districts covered by the Cottage and voluntary schemes described above.

Thus, an overall total of some 361,000 persons or 74 per cent of the entire population of Newfoundland were covered by one or more of these plans.

Subsection 5 - Services for the Disabled and Chronically Ill

The success of rehabilitation programs for injured workers, war veterans, handicapped children, and other disability groups has encouraged more recent efforts to extend rehabilitation services to all handicapped persons. Physical medicine and rehabilitation departments have been established in the teaching hospitals and most veterans' and children's hospitals. Complementing these are some 48 independent rehabilitation centres, including 27 children's centres and four workmen's compensation centres. Hospital services available to in-patients and out-patients include physical medicine, physiotherapy, occupational

therapy, and social services; most of the children's hospitals and the teaching hospitals also supply speech therapy. The rehabilitation centres provide comprehensive medical, psychosocial, and vocational services to more severely disabled persons who require intensive or long-term therapy. In addition, the children's hospitals and centres operate special education classes. Provincial and community agencies such as those providing vocational rehabilitation and home care services co-operate in the rehabilitation of disabled children and adults.

Most large general hospitals conduct special out-patient clinics for disabilities such as arthritis and rheumatism, diabetes, glaucoma, speech and hearing defects, heart diseases, orthopedic and neurological conditions. Voluntary agencies, which are concerned with specific disability groups such as arthritics, the blind, the deaf, children suffering from cystic fibrosis, haemophilia, or muscular dystrophy, the mentally ill or retarded, or disabled persons generally, are also broadening their rehabilitation services. These agencies provide such services as counselling, the supply of personal aids and appliances, employment and education, and sheltered workshops and also participate in the provision of services for the homebound. More than 150 sheltered workshops were in operation in 1965, serving handicapped persons. Organized home care programs, under either hospital or community sponsorship, have been established in the principal cities, providing nursing, homemaker, physiotherapy and other services to the disabled, the chronically ill and the aged in their own homes. Several provincial health departments have instituted home nursing services to residents of outlying districts.

Provincial health, welfare, and education departments and voluntary agencies are developing specialized services for physically and mentally handicapped children. Most provinces have established registries of handicapped children of varying coverage in co-operation with physicians, health units, hospitals, and other agencies. Such registries, which are increasingly useful sources of morbidity statistics including congenital anomalies, assist in the planning and co-ordination of rehabilitation services. In addition to medical rehabilitation, health departments and the crippled children's societies provide family counselling, recreation, transportation, and foster home care; travelling clinics extend periodic diagnostic and treatment services to outlying areas. Special schools or classes for various groups of handicapped children are established by local school boards in the main cities, but most of the 10 residential schools for the deaf and the six for the blind are operated by the provincial education departments.

The establishment of three regional prosthetic research and training units in rehabilitation centres in Montreal, Toronto, and Winnipeg and the Bio-Engineering Institute of the University of New Brunswick, supported by National Health Grants, are significant developments. The three regional centres and several juvenile amputee clinics in other cities are rehabilitating children with limb deformities or amputations. A federal-provincial program assists in the extraordinary rehabilitation, maintenance, and counselling costs on behalf of children with thalidomide-induced defects. The transfer of prosthetic service for veterans to the Department of National Health and Welfare on January 1, 1966, makes it possible for the provinces to extend these services to non-veterans.

Services for the disabled and chronically ill are hampered by a shortage of qualified personnel, especially in the para-medical field. Helping to solve this shortage are the eight university schools offering training in physical therapy and/or occupational therapy and the three providing training in audiology and speech therapy.

The Department of National Health and Welfare assists the provinces in their rehabilitation programs through the National Health Grants, especially the Medical Rehabilitation and Crippled Children Grant of $2,885,550 (1965-66). These grants are used to develop medical rehabilitation services and facilities, to support the training of medical rehabilitation personnel (through grants to the university schools and student bursaries), and for equipment and research.

Section 4 - International Health

Canada actively assists and co-operates with the World Health Organization and the other specialized agencies of the United Nations whose programs have a substantial health component or orientation. Capital and technical assistance are provided to developing countries through the Colombo Plan and other bilateral aid programs. Health training is provided for a number of persons coming to Canada each year under the different technical co-operation schemes; during 1965, 112 trainees arrived, bringing the total number of trainees in Canada during the year to 282. These persons were working in a wide range of health disciplines under the External Aid Program, but with greatest concentration in undergraduate medicine and in public health and nursing specialties.

Canadian experts in health legislation, health administration, and related areas undertook specific assignments abroad during the year, and teachers and specialists in a number of clinical fields were provided in response to requests

from the developing countries. Capital assistance, primarily through the provision of cobalt beam therapy units for cancer treatment centres in the Colombo Plan area, was continued.

Canada concluded its membership on the Executive Board of the World Health Organization in May 1965, but its term of office on the Executive Board of UNICEF was renewed at the beginning of the year. The Deputy Minister of National Welfare, Canada's representative on the Board, was elected Chairman for the period commencing February 1966 through July 1968.

To carry out Canada's obligations under the International Sanitary Conventions, the Department of National Health and Welfare maintains quarantine measures for ships and aircraft entering Canadian ports and provides accommodation and necessary medical care for persons arriving in Canada who require quarantine (see p. 9).

The Department is responsible for the enforcement of regulations governing the handling and shipping of shellfish under the International Shellfish Agreement between Canada and the United States and, at the request of the International Joint Commission, participates in studies connected with control of pollution of boundary waters between Canada and the United States as well as with problems caused by atmospheric pollution. Other international health responsibilities include the custody and distribution of biological, vitamin, and hormone standards for the World Health Organization and certain duties in connection with the Single Convention on Narcotic Drugs - 1961, as well as Canada's representation on the Narcotic Commission of the United Nations.

PART II - PUBLIC WELFARE AND SOCIAL SECURITY

Responsibility for social welfare is shared by all levels of government. Comprehensive income-maintenance measures such as the Canada Pension Plan, old age security pensions, family allowances, and programs such as unemployment insurance and the National Employment Service where nation-wide co-ordination is required, are administered federally. Substantial federal aid is given to the provinces in meeting the costs of public assistance. The federal government also provides services for special groups such as veterans, Indians, Eskimos, and immigrants.

The Department of National Health and Welfare is generally responsible for federal welfare matters; the Departments of Veterans Affairs, Citizenship and Immigration, and Northern Affairs and National Resources also operate programs for specific groups. The Unemployment Insurance Commission is responsible for the operation of unemployment insurance. The National Employment Service is administered by the Department of Labour.

Administration of welfare services is primarily the responsibility of the provinces but the provision of services is often assumed by local authorities, generally with financial aid from the province.

Section 1 - Federal Welfare Programs

Subsection 1 - Canada Pension Plan

The legislation under which the Canada Pension Plan is established was enacted in 1965, and provides an important new component in Canada's social security system. The Plan is designed to provide, for members of the labour force, an organized program whereby each contributor builds up a right to a retirement pension, the amount of which is related to his previous earnings pattern. The Plan also provides benefits to a disabled contributor and his dependent children and, at the contributor's death, a lump sum death benefit together with monthly benefits for his widow and children. Contributions began to be collected in January 1966.

The Canada Pension Plan is a contributory social insurance program which, together with its Quebec counterpart, will apply to about 92 per cent of the Canadian labour force. There are certain minor exemptions from coverage. Employees who earn $600 or less in a calendar year or self-employed persons who earn less than $800 do not pay contributions for that year.

The Canada and Quebec Pension Plans are closely co-ordinated and operate together as one and the same Plan. If an employee covered by the Canada Pension Plan takes employment in Quebec, or if a self-employed person moves his residence to that Province, his contributions to the Quebec Pension Plan will produce the same benefits as if they had been made to the Canada Pension Plan. The reverse also applies. Anyone employed in Quebec who later takes up work in any other part of the country will get the same benefits as if he had contributed to either plan throughout.

The Canada Pension Plan is financed by contributions of employees, employers, and self-employed persons and by interest earned by the fund. The first $600 of each contributor's annual earnings is exempt from contributions. On earnings above that amount and up to the present maximum on pensionable earnings of $5,000 a year, the employee makes a contribution of 1.8 per cent, with his employer paying a matching contribution. Self-employed people, being in effect both employer and employee, contribute at the combined rate of 3.6 per cent, also on annual earnings between $600 and $5,000.

The contributory limits under the Canada Pension Plan will be adjusted with changing economic conditions. For the first two years of the Plan the limits are $5,000 and $600. For the next eight years these limits will be adjusted by means of a specially constructed Pension Index which will reflect changes in the Consumer Price Index. After 1975, the contributory limits will be adjusted according to changes in an Earnings Index which will be based on a long-term moving average of national wages and salaries.

Retirement pensions under the Canada Pension Plan will come into effect according to the following staging. In 1967, retired contributors age 68 or over will be able to claim retirement pensions; in 1968, those who are age 67 or over can do so; in 1969, the eligible age will be 66 or over; while in 1970 and afterwards, contributors age 65 or over will be able to claim their retirement pensions.

A retirement pension will be 25 per cent of a contributor's average pensionable earnings. His pensionable earnings include not only those earnings on which contributions were made but, also, the $600 that were exempt from contributions. For the purpose of calculating a contributor's pension, his earnings for each year will be adjusted so that they bear the same relationship to the maximum pensionable earnings in force at the time the pension begins that his earnings bore to the upper limit prevailing in the year in which they were actually received. His total adjusted pensionable earnings under the program will be averaged over the entire period from the commencement of the program on January 1, 1966, or from age 18 whichever is later, to the date the pension is first paid; but in no case will they be averaged over less than 120 months, unless a disability pension has been paid to the contributor in the interim. During the first ten years of the program, partial retirement pensions are payable. It will not be until 1976 that these pensions become payable at their full rates.

After 1975, certain periods of low earnings, or no earnings at all, can be disregarded in determining the average earnings on which retirement pensions are to be based. Contributory earnings received between ages 65 and 70 are to be substituted for lower or nil earnings of earlier periods of the same duration. In addition, 15 per cent of the contributory period then remaining is dropped out, providing that the reduced contributory period is not less than 120 months. These drop-out provisions make it possible for the person to receive a higher pension than would otherwise be the case.

A retirement pension is payable at any time between the ages of 65 and 70, provided the contributor has then retired from regular employment. If he earns up to $900 a year, he is considered as having been retired for purposes of applying for his pension. Those taking up new employment after starting to draw a retirement pension will be required to pass an earnings test. For earnings between $900 and $1,500 in any year, the pension will be reduced by one-half of the difference between the actual earnings and $900, with the maximum reduction in this range being $300. When earnings exceed $1,500, the retirement pension will be reduced by $300 plus all earnings in excess of $1,500. However, no reduction will be made in the pension for any month in which the pensioner's earnings are $75 or less, no matter what his earnings are for the entire year. The pension is payable at the full rate when the person attains age 70 regardless of earnings. Retirement and earnings test limits will be adjusted as the Earnings Index changes.

Pensions for disabled contributors and for their dependent children will first be payable in the spring of 1970. Survivors' benefits, including pensions for widows and disabled widowers, orphans' benefits and the death benefit will first be payable early in 1968.

A contributor who becomes disabled after making contributions for the required period of time will be entitled to a disability pension consisting of a flat rate component, initially $25 monthly, and an earnings-related component amounting to 75 per cent of a retirement pension, calculated as if he had then reached 65 years of age. A contributor is considered to be disabled if he has a physical or mental disability so severe and likely to continue so long that he cannot get steady work. In calculating this pension, earnings are averaged over the period from age 18 or January 1, 1966 whichever is later, until the date the disability pension becomes payable, the minimum period for averaging being 60 months. In addition, benefits will be payable for the dependent children of a disability pensioner; that is, on behalf of unmarried children under age 18, or up to age 25 if in full-time attendance at school or university. The monthly rate is $25 for each of the first four eligible children and $12.50 for each additional child.

A widow age 45 to 64 at her husband's death, a disabled widow under age 65, and a widow under age 65 with dependent children will be entitled to a widow's pension if her husband has made the required number of contributions. It consists of a flat-rate component, initially $25 a month, and an earnings-related component equal to 37.5 per cent of the retirement pension payable to her deceased husband. If he is under age 65 at the time of his death the pension is calculated as if he had actually attained age 65 at that time. A widow who is not disabled and who does not have dependent children receives a reduced pension if she is under age 45 at the death of her husband; if she is under age 35 no widow's pension is payable until she reaches 65 years of age unless she becomes disabled in the interim. The definition of disability applicable to the disabled contributor is also applied in determining whether or not a widow or widower is disabled.

Benefits payable for the children of a deceased contributor are the same as those provided for the dependent children of a disabled pensioner.

A woman widowed at age 65 or over or a widow reaching age 65 will receive a pension of 60 per cent of her husband's retirement pension. If the husband was under age 65 when he died, his retirement pension is calculated as if he had then attained age 65. There will be widows aged 65 or over who

will also be entitled to retirement pensions of their own. For such women, two alternative formulae are provided for the re-calculation of their widow's pensions, so that they may receive the more advantageous amount.

A pension is provided for the disabled widower of a contributor if he was disabled at the time of his wife's death and was, at that time, wholly or substantially maintained by her. The rate of his pension is the same as that for a woman widowed between age 45 and 65. For a disabled widower reaching age 65, or for a person becoming a disabled widower after age 65 the rate of pension is the same as for a widow of the same age. A disabled widower entitled to his own retirement pension is also provided with two alternative formulae for purposes of calculating his total retirement income. The disabled widower must continue to prove disability for the duration of his pension.

A lump sum death benefit is payable subject to the same qualifying conditions as pertain to other survivors' benefits. The amount of the benefit is six times the monthly retirement benefit that is being (or would be) paid to the contributor in the month of his death, but cannot exceed 10 per cent of the maximum on pensionable earnings for that year. If the contributor is under 65 years of age when he dies, the retirement pension will be calculated as if he were 65 at the date of his death.

Canada Pension Plan benefits, once they have commenced to be paid, will be subject to annual adjustments in accordance with upward changes in the Pension Index. Benefits are payable no matter where the beneficiary may live whether in Canada or any other country.

The Department of National Health and Welfare administers the Canada Pension Plan through its head office in Ottawa and District Offices located in various centres across Canada. Contributions are collected by the Department of National Revenue. Employers are responsible for making deductions of contributions from their employees' earnings and for remitting these, along with their own matching contributions, to the Department of National Revenue. Self-employed persons make payments directly at the time such people normally pay their income tax.

Everyone covered by the Plan must obtain a Social Insurance Number in order to identify and maintain his individual Record of Earnings. Even if a person does not obtain a number, he is still required to make contributions, and any earnings received before a number is obtained may not be taken into account when calculating that individual's pension.

Appeals in connection with coverage and contributions may be made to the Minister of National Revenue. If an employee is not then satisfied, he may appeal further to the Pension Appeals Board whose decision is final. A self-employed contributor follows the appeal procedures of the Income Tax Act. With regard to benefits, there is a three-stage appeal procedure: first, to the Minister of National Health and Welfare; secondly, to a Review Committee; and thirdly, to the Pension Appeals Board whose decision is final and binding.

Contributions to the Plan, other than those required for immediate administrative costs and payment of benefits, may be borrowed by a provincial government on the basis of the relationship between contributions by residents of that province and all contributions at rates of interest determined in accordance with the legislation.

Provision is made for the establishment of an advisory committee to review the operation of the Act, the state of the investment fund, and the adequacy of the coverage and benefits provided under the legislation.

The legislation provides authority whereby the government may enter into reciprocal arrangements with other countries where there is a common interest in as full coverage as possible and in the portability of pensions and where mutually satisfactory agreements can be reached.

Subsection 2 - Old Age Security

Under the Old Age Security Act of 1951, as amended, a universal pension of $75 a month is payable by the federal government to all persons who meet the residence and age qualifications. Until 1965, the pension was payable to those aged 70 or over, but in 1966 it is payable to persons aged 69 or over, in 1967 to those aged 68 or over, and so on until by 1970 $75 a month will be payable to everyone aged 65 or more. In 1968 and succeeding years, the amount of the Old Age Security pension will be adjusted in line with changes in the Pension Index developed for the Canada Pension Plan.

The Old Age Security pension is payable to a person of attained age who has resided in Canada for ten years immediately preceding his application for the pension. Any gaps in the ten-year period may be offset if the applicant had resided in Canada in earlier years for periods of time equal in total to double the length of the gaps; in this case, however, the applicant must also have resided in Canada for one year immediately before his application for pension. A recent amendment authorizes the payment of the Old Age Security pension to persons of attained age who have had 40 years of

residence in Canada since age 18, thus making eligible for the pension those who have left Canada before reaching the qualifying age but who have spent virtually all of their working lives in Canada. A pensioner may absent himself from Canada and continue to receive pension payments. If he has lived in Canada for 25 years since his twenty-first birthday, payment of his pension outside of Canada may continue indefinitely; if he has not so resided, payment is continued for six months, in addition to the month of departure, and is then suspended, to be resumed only with the month in which he returns to Canada.

The program is administered by the Department of National Health and Welfare through regional offices in each provincial capital to which application is made for pension. It is financed on the pay-as-you-go method through a 3 per cent sales tax, a 3 per cent tax on corporation income, and, subject to a limit of $120 a year, a 4 per cent tax on taxable personal income. Yields from these taxes are paid into the Old Age Security Fund; if they are insufficient to meet the pension payments, temporary loans are made from the Consolidated Revenue Fund. Operations of the Old Age Security Fund for the fiscal years ended March 31, 1960 to 1965 are shown in Table 12, and province-by-province statistics of pensioners and pension-payments appear in Table 13.

Persons in receipt of old age assistance who reach the eligible age are automatically transferred to old age security. Others make application to the regional offices. Recipients of old age security who are in need may receive supplementary aid under general assistance programs in the provinces. Where the amount of aid is determined through an individual assessment of need, which takes the recipient's requirements and resources into consideration, the federal government may share in it under the Unemployment Assistance Act.

Subsection 3 - Family Allowances

The Family Allowances Act of 1944 is designed to assist in providing equal opportunities for all Canadian children. The allowances do not involve a means test and are paid from the federal Consolidated Revenue Fund. They do not constitute taxable income but there is a smaller income tax exemption for children eligible for allowances.

Allowances are payable in respect of every child under the age of 16 years who was born in Canada, or who has been a resident of the country for one year, or whose father or mother was domiciled in Canada for three years immediately prior to the birth of the child. Payment is made by cheque each month, normally to the mother, although any person who

TABLE 12 - OPERATION OF THE OLD AGE SECURITY FUND, YEARS ENDED MARCH 31, 1960 TO 1966

Item	1959-60	1960-61	1961-62	1962-63	1963-64	1964-65	1965-66
	$	$	$	$	$	$	$
Source of funds:							
Sales tax	270,000,055	270,231,478	284,879,239	302,238,927	331,760,067	383,151,254	522,085,844
Corporation income tax	91,336,000	103,500,000	100,125,000	115,250,000	115,750,000	145,250,000	152,250,000
Individual income tax	185,550,000	229,400,000	258,950,000	273,650,000	302,600,000	431,900,000	494,900,000
Loan from consolidated revenue fund	28,000,991	-	-	41,679,066	58,281,233	-	-
Balance brought forward	-	-	-	1,563,639	-	-	-
Total	574,887,046	603,131,478	643,954,239	734,381,632	808,391,300	960,301,254	1,169,235,844
Application of funds:							
Benefit payments	574,887,046	592,413,283	625,107,804	734,381,632	808,391,300	885,294,468	927,299,487
Repayment of loans to consolidated revenue fund	-	10,718,195	17,282,796	-	-	75,006,786	24,953,515
Balance carried over	-	-	1,563,639	-	-	-	216,982,842
Total	574,887,046	603,131,478	643,954,239	734,381,632	808,391,300	960,301,254	1,169,235,844

TABLE 13 - OLD AGE SECURITY STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966

Province and year	Pensioners in March	Net pensions paid during fiscal year	Province and year	Pensioners in March	Net pensions paid during fiscal year
	No.	$		No.	$
Newfoundland..... 1963	18,184	14,013,832	Manitoba..... 1963	57,692	44,617,405
1964	18,477	15,376,636	1964	58,850	48,874,928
1965	18,886	16,811,166	1965	59,818	53,360,235
1966	21,184	17,586,159	1966	65,758	55,494,509
Prince Edward Island..... 1963	7,635	5,962,922	Saskatchewan..... 1963	59,690	46,334,646
1964	7,792	6,493,258	1964	60,587	50,751,907
1965	7,949	7,118,615	1965	61,257	55,063,268
1966	8,809	7,447,170	1966	66,638	56,755,191
Nova Scotia..... 1963	43,583	33,817,492	Alberta..... 1963	64,286	49,787,140
1964	44,424	37,063,710	1964	65,746	54,835,096
1965	45,014	40,399,804	1965	67,245	60,052,938
1966	49,801	42,048,599	1966	74,514	62,793,976
New Brunswick..... 1963	31,935	24,858,331	British Columbia..... 1963	120,678	93,362,860
1964	32,592	27,247,749	1964	122,732	102,639,328
1965	33,262	29,780,719	1965	124,262	111,327,361
1966	36,852	30,994,768	1966	135,556	115,292,880
Quebec..... 1963	202,405	155,359,915	Yukon and North-west Territories.... 1963	676	524,445
1964	207,917	171,996,794	1964	680	564,696
1965	214,294	189,682,327	1965	707	633,415
1966	242,865	201,031,152	1966	802	660,570
Ontario..... 1963	344,002	265,742,644	Canada..... 1963	950,766	734,381,632
1964	352,004	292,547,198	1964	971,801	808,391,300
1965	360,888	321,064,620	1965	993,582	885,294,468
1966	402,997	337,194,513	1966	1,105,776	927,299,487

substantially maintains the child may be paid the allowance on his behalf. Allowances are paid at the monthly rate of $6 for each child under 10 years of age and $8 for each child aged 10 or over but under 16 years. If the allowances are not spent for the purposes outlined in the Act, payment may be discontinued or made to some other person or agency on behalf of the child. Allowances are not payable for any child who fails to comply with provincial school regulations or on behalf of a girl who is married and under 16 years of age.

The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital. The Regional Director located at Edmonton is also responsible for administering the accounts of residents in the Yukon and Northwest Territories.

The Federal Government pays family assistance, at the rates applicable for family allowances, for each child under 16 years of age resident in Canada and supported by an immigrant who has landed for permanent residence in Canada, or by a Canadian returned to Canada to reside permanently. The assistance, which is payable monthly for the first year of the child's residence in Canada, is intended to bridge the gap until the child becomes eligible for family allowances.

Subsection 4 - Youth Allowances

Legislation providing for a program of youth allowances was assented to on July 16, 1964 and became effective September 1964. The federal government does not provide youth allowances in Quebec, which has its own program, but that province is compensated by a tax abatement adjusted to equal the amount that the federal government would otherwise have paid in allowances to Quebec residents.

Under the federal program, monthly allowances of $10 are payable in respect of all dependent youths age 16 and 17 who are receiving full-time educational training or are precluded from doing so by reason of physical or mental infirmity. Both the parent or guardian and the youth must normally be physically present and living in a province other than Quebec. The allowance is not payable to a parent who resides in Quebec or outside Canada regardless of where his child may be attending school. However, a dependent youth may attend school in Quebec or outside Canada or, if disabled, receive care or training in Quebec or outside Canada, and still be considered eligible, on the basis that he is a resident of one of a province other than Quebec but is temporarily absent.

TABLE 14 - FAMILY ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966

Province and year		Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance(1)		Net total allowances paid during fiscal year
					Per family	Per child	
		No.	No.	No.	$	$	$
Newfoundland.....	1963	66,657	207,120	3.11	20.80	6.70	16,562,083
	1964	67,635	209,180	3.09	20.75	6.71	16,747,021
	1965	68,418	210,016	3.07	20.59	6.71	16,871,056
	1966	69,346	210,512	3.04	20.40	6.71	16,945,059
Prince Edward Island..	1963	14,344	40,423	2.82	18.99	6.74	3,259,952
	1964	14,377	40,524	2.82	19.05	6.76	3,274,057
	1965	14,191	40,201	2.83	19.12	6.75	3,266,459
	1966	14,054	39,632	2.82	19.03	6.75	3,231,716
Nova Scotia.....	1963	106,018	271,476	2.56	17.14	6.69	21,838,772
	1964	105,754	271,336	2.57	17.20	6.70	21,790,680
	1965	105,163	269,845	2.57	17.24	6.72	21,776,091
	1966	104,856	267,689	2.55	17.18	6.74	21,636,528
New Brunswick.....	1963	83,272	239,507	2.87	19.33	6.72	19,340,514
	1964	82,711	237,093	2.87	19.29	6.73	19,198,184
	1965	82,578	235,714	2.85	19.24	6.74	19,069,036
	1966	82,851	233,724	2.82	19.05	6.76	18,982,908
Quebec.....	1963	752,413	1,999,894	2.66	17.87	6.72	160,299,079
	1964	766,364	2,017,190	2.63	17.74	6.74	162,172,423
	1965	780,305	2,037,605	2.61	17.60	6.74	163,888,091
	1966	792,955	2,043,428	2.57	17.38	6.76	164,972,052
Ontario.....	1963	939,314	2,172,643	2.31	15.44	6.68	172,711,354
	1964	949,955	2,209,982	2.33	15.56	6.69	175,544,729
	1965	964,468	2,248,642	2.33	15.65	6.71	179,056,316
	1966	983,502	2,284,059	2.32	15.61	6.73	182,377,587
Manitoba.....	1963	132,937	319,564	2.40	16.07	6.69	25,523,719
	1964	133,105	321,413	2.41	16.17	6.69	25,727,440
	1965	133,500	323,862	2.43	16.24	6.69	25,926,570
	1966	132,148	321,747	2.43	16.30	6.71	25,925,991

(1) Based on gross payment for March.

TABLE 14 - FAMILY ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966 (Concluded)

Province and year	Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance(1)		Net total allowances paid during fiscal year
				Per family	Per child	
	No.	No.	No.	$	$	$
Saskatchewan..... 1963	131,066	331,394	2.53	16.89	6.68	26,539,801
1964	131,240	333,051	2.53	16.97	6.69	26,650,259
1965	131,449	335,381	2.55	17.09	6.70	26,891,288
1966	131,266	332,952	2.54	17.11	6.74	26,988,369
Alberta..... 1963	208,646	509,805	2.44	16.29	6.67	40,315,733
1964	211,105	519,140	2.46	16.47	6.70	41,227,721
1965	212,630	525,976	2.47	16.57	6.70	41,996,327
1966	213,489	525,859	2.46	16.58	6.74	42,345,742
British Columbia..... 1963	239,496	550,380	2.30	15.40	6.70	43,834,184
1964	242,789	561,174	2.31	15.51	6.71	44,712,129
1965	247,635	573,714	2.32	15.58	6.73	45,745,199
1966	254,871	589,041	2.31	15.60	6.75	47,006,572
Yukon and Northwest Territories..... 1963	6,582	17,674	2.68	17.03	6.34	1,341,158
1964	6,237	16,074	2.58	17.21	6.68	1,267,581
1965	6,212	16,057	2.58	17.19	6.65	1,288,798
1966	6,298	16,414	2.61	17.21	6.60	1,322,300
Canada..... 1963	2,680,745	6,659,880	2.48	16.63	6.69	531,566,349
1964	2,711,272	6,736,157	2.48	16.67	6.71	538,312,224
1965	2,746,549	6,817,013	2.48	16.68	6.72	545,775,231
1966	2,785,636	6,865,057	2.46	16.59	6.74	551,734,824

(1) Based on gross payment for March.

Allowances normally commence with the month following that in which family allowances cease and continue until the school year terminates. They are paid retroactively for the summer months on the youth's return to school at the commencement of the new school year. Allowances for a disabled child not attending school, however, are payable continuously throughout the year. Should the youth leave school, leave the country permanently, cease to be maintained, take up residence in Quebec, or die, the allowance will cease. Otherwise, the youth allowance continues until the end of the month in which the youth reaches age 18. Youth allowances are considered not to be income for any purpose of the Income Tax Act.

The program is administered by the Department of National Health and Welfare. The national director of the family allowances and old age security programs also administers youth allowances, assisted by regional directors located in each of the provincial capitals other than Quebec City. The costs of youth allowances are met from the Consolidated Revenue Fund.

Section 2 - Federal-Provincial Welfare Programs

Subsection 1 - Canada Assistance Plan

The Canada Assistance Plan, a comprehensive public assistance measure to complement the provisions of the Canada Pension Plan, was introduced in the House of Commons June 14, 1966.

The proposed plan would provide a single administrative framework for federal sharing with the provinces in costs of assistance and of welfare services. It is designed to replace the four existing programs of Unemployment Assistance, Old Age Assistance, Blind Persons' Allowances, and Disabled Persons' Allowances. The provinces will, however, have the option of continuing separate administration of the categorical programs, and the provision for contracting out that now applies to the four programs under the Established Programs (Interim Arrangements) Act will extend to the Canada Assistance Plan.

The plan authorizes the federal government to enter into an agreement with any province to share, on a 50:50 basis, the costs of assistance to persons in need and of improving or extending welfare services. From April 1, 1966, the plan will cover those costs shared under the Unemployment Assistance Act (see p. 74) and will extend federal sharing to the following costs: assistance to needy mothers with dependent children, maintenance of children in the care of provincially-approved child welfare agencies, health care services to needy persons, and extension of welfare services to prevent and remove causes of poverty and to assist persons receiving assistance to achieve the greatest possible degree of self-support.

TABLE 15 - YOUTH ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 AND 1966

Province or Territory	Youths for whom allowance paid in March						Net total allowance paid during fiscal year	
	Attending school full-time		Having physical or mental infirmity		Total youths			
	1965	1966	1965	1966	1965	1966	1965(1)	1966
	No.	No.	No.	No.	No.	No.	$	$
Newfoundland	13,673	14,970	125	151	13,798	15,121	881,777	1,591,901
Prince Edward Island	3,391	3,553	44	40	3,435	3,593	231,142	395,465
Nova Scotia	23,385	22,972	164	176	23,549	23,148	1,590,976	2,691,768
New Brunswick	19,885	19,868	194	204	20,079	20,072	1,352,716	2,311,244
Ontario	186,988	189,923	725	783	187,713	190,706	12,652,036	21,978,399
Manitoba	28,017	27,930	106	148	28,123	28,078	1,916,217	3,249,490
Saskatchewan	29,146	29,605	107	94	29,253	29,699	1,990,364	3,414,834
Alberta	41,297	41,877	154	181	41,451	42,058	2,806,661	4,836,771
British Columbia	50,002	51,556	137	214	50,139	51,770	3,415,086	5,934,292
Yukon	258	258	-	1	258	259	17,060	30,210
Northwest Territories	235	290	-	-	235	290	15,780	34,176
Total	396,277	402,802	1,756	1,992	398,033	404,794	26,869,815	46,468,550

(1) Covers seven months; program became effective September 1, 1964.

The only eligibility requirement under the proposed legislation is that of need, irrespective of the cause of need and without reference to employment status. Need is to be determined by a needs test. No residence requirements are specified and a province may not require a period of previous residence in the province as a condition of eligibility for assistance or for continued assistance. No maximum amounts of assistance are set, and rates of assistance and conditions of aid are set by the provinces. The resulting flexibility will enable the provinces to adjust rates to local conditions and to take into account the needs of special groups by providing a differential in benefits or conditions of eligibility.

The costs of improving or extending welfare services, for the purposes of federal reimbursement, may be calculated either as the amount by which the cost, to the province and the municipalities, of providing welfare services exceeds the cost in the base year ended March 31, 1965, or as the cost, to the province and the municipalities, of employing persons who are engaged wholly or mainly in the performance of welfare service functions and who are employed in positions filled after March 31, 1965.

At the option of the province, separate agreements may be entered into providing for the sharing of costs of work activity projects to prepare persons in need for entry or return to employment and for the sharing of costs of extensions of provincial welfare services to Indians on reserves, Crown lands or in unorganized territory. The former agreement would cover 50 per cent of certain operating and maintenance costs; the latter may provide for a federal contribution in excess of 50 per cent.

Subsection 2 - Old Age Assistance

The Old Age Assistance Act of 1951, as amended, provides for federal reimbursement to the provinces for assistance to persons aged 65 or over who are in need and who have resided in Canada for at least ten years or who, if absent from Canada during this period, have been present in Canada prior to the commencement of the ten-year period for double any period of absence during the ten years. A pensioner is transferred to old age security on reaching the age of eligibility for it. The federal contribution may not exceed 50 per cent of $75 a month or of the assistance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of assistance payable, the maximum income allowed, and other conditions of eligibility.

Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement as an equalization payment.

For an unmarried person, total income allowed, including assistance, may not exceed $1,260 a year. For a married couple it may not exceed $2,220 a year or, when the spouse is blind within the meaning of the Blind Persons Act, $2,580 a year. Assistance is not paid to a person receiving an old age security pension or an allowance under the Blind Persons Act, the Disabled Persons Act, or the War Veterans Allowance Act.

Recipients of old age assistance who are in need may receive supplementary aid under general assistance programs in the provinces. Where the amount of aid is determined through an individual assessment of need, which takes the recipient's requirements and resources into consideration, the federal government may share in it under the Unemployment Assistance Act.

Subsection 3 - Allowances for Blind Persons

The Blind Persons Act of 1951, as amended, provides for federal reimbursement to the provinces for allowances to blind persons aged 18 or over who are in need and who meet the necessary requirements. The federal contribution may not exceed 75 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable and the maximum income allowed. Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement as an equalization payment.

To qualify for an allowance a person must meet the required definition of blindness and have resided in Canada for ten years immediately preceding the commencement of the allowance or, if absent from Canada during this period, must have been present in Canada prior to its commencement for a period equal to double any period of absence during the period. For an unmarried person, total income including the allowance may not exceed $1,500 a year; for a person with no spouse with one or more dependent children, $1,980; for a married couple, $2,580. When the spouse is also blind, income of the couple may not exceed $2,700. Allowances are not payable to a person receiving assistance under the Old Age Assistance Act, an allowance under the Disabled Persons Act or the War Veterans Allowance Act, a pension under the Old Age Security Act, or a pension for blindness under the Pensions Act.

TABLE 16 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966

Province and year		Recipients in March	Average amount of monthly assistance	Federal government contribution during year(a)
		No.	$	$
Newfoundland	1963	5,187	63.00	1,987,213
	1964	5,081	62.79	1,945,021
	1965	5,088	72.41	2,220,908
	1966	4,080	72.14	2,121,068
Prince Edward Island	1963	1,037	60.35	375,350
	1964	1,130	60.38	394,947
	1965	1,229	70.43	508,587
	1966	988	70.73	498,378
Nova Scotia	1963	5,421	59.76	2,007,871
	1964	5,509	69.11	2,084,088
	1965	5,574	68.53	2,302,860
	1966	4,423	67.96	2,188,257
New Brunswick	1963	5,491	61.58	2,065,950
	1964	5,447	70.96	2,121,388
	1965	5,356	70.28	2,303,178
	1966	4,200	69.72	2,161,779
Quebec	1963	37,086	61.48	13,793,745
	1964	38,206	60.96	13,860,075
	1965	39,239	70.35	16,589,045
	1966	(b)	(b)	(b)
Ontario	1963	23,925	58.80	8,458,293
	1964	25,197	67.59	9,134,698
	1965	26,049	67.03	10,465,257
	1966	19,991	67.28	10,006,001
Manitoba	1963	5,448	60.83	2,001,606
	1964	5,436	70.06	2,105,940
	1965	5,520	69.15	2,329,362
	1966	4,241	69.02	2,188,141

(a) Maximum assistance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Effective April 1, 1965, assistance ceased to be paid to the province of Quebec under this program.

TABLE 16 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966 (Concluded)

Province and year		Recipients in March	Average amount of monthly assistance	Federal government contribution during year(a)
		No.	$	$
Saskatchewan	1963	5,866	59.63	2,220,539
	1964	5,549	68.59	2,151,490
	1965	5,463	69.04	2,294,105
	1966	3,975	68.87	2,097,642
Alberta	1963	6,479	60.30	2,523,720
	1964	6,644	69.56	2,559,785
	1965	6,810	69.00	2,901,039
	1966	5,453	68.61	2,795,633
British Columbia	1963	7,039	62.26	2,675,207
	1964	6,864	72.01	2,781,892
	1965	6,829	71.82	2,991,013
	1966	5,478	71.74	2,836,336
Yukon Territory	1963	34	64.47	15,287
	1964	31	65.00	12,113
	1965	31	75.00	13,880
	1966	26	75.00	13,553
Northwest Territories	1963	144	63.36	54,275
	1964	147	64.40	56,743
	1965	166	74.32	71,721
	1966	133	73.64	73,722
Canada	1963	103,159	60.68	38,179,057
	1964	105,241	65.72	39,208,181
	1965	107,354	69.43	44,990,955
	1966	52,988(b)	68.85(b)	26,980,510(b)

(a) Maximum assistance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Excludes Quebec.

Recipients of blindness allowances who are in need may receive supplementary aid under general assistance programs in the provinces. Where the amount of aid is determined through an individual assessment of need, which takes the recipient's requirements and resources into consideration, the federal government may share in it under the Unemployment Assistance Act.

Subsection 4 - Allowances for Disabled Persons

The Disabled Persons Act of 1954, as amended, provides for federal reimbursement to the provinces for allowances paid to permanently and totally disabled persons age 18 or over who are in need and who have resided in Canada for at least ten years immediately preceding commencement of allowance or, if absent from Canada during this period, have been present in Canada prior to its commencement for a period equal to double any period of absence during the period. To qualify for an allowance a person must meet the definition of "permanent and total disability" set out in the Regulations to the Act, which requires that a person must be suffering from a major physiological, anatomical, or psychological impairment, verified by objective medical findings; the impairment must be one that is likely to continue indefinitely without substantial improvement and that will severely limit activities of normal living. The federal contribution may not exceed 50 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable, the maximum income allowed, and other conditions of eligibility. Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement as an equalization payment.

For an unmarried person, total income including the allowance may not exceed $1,260 a year. For a married couple the limit is $2,220 a year except that if the spouse is blind within the meaning of the Blind Persons Act, income of the couple may not exceed $2,580 a year. Allowances are not paid to a person receiving an allowance under the Blind Persons Act or the War Veterans Allowance Act, assistance under the Old Age Assistance Act, a pension under the Old Age Security Act, or a mother's allowance.

The allowance is not payable to a patient in a mental institution or tuberculosis sanatorium. A recipient who is resident in a nursing home, an infirmary, a home for the aged, an institution for the care of incurables, or a private,

TABLE 17 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(a)
		No.	$	$
Newfoundland	1963	429	63.70	247,377
	1964	436	63.66	246,924
	1965	460	73.49	300,474
	1966	445	73.27	304,203
Prince Edward Island	1963	83	63.21	47,103
	1964	79	64.43	46,778
	1965	71	73.47	51,020
	1966	72	72.92	47,372
Nova Scotia	1963	792	63.08	450,275
	1964	775	73.00	468,866
	1965	750	73.41	509,671
	1966	714	72.72	487,504
New Brunswick	1963	701	63.79	410,317
	1964	679	73.77	418,037
	1965	679	74.10	456,965
	1966	626	73.35	438,437
Quebec	1963	2,891	63.74	1,662,937
	1964	2,855	63.65	1,642,869
	1965	2,843	73.47	1,892,813
	1966	(b)	(b)	(b)
Ontario	1963	1,877	58.73	992,300
	1964	1,902	67.59	1,045,329
	1965	1,906	67.93	1,179,138
	1966	1,820	67.54	1,153,040
Manitoba	1963	379	68.80	214,163
	1964	383	72.67	230,264
	1965	401	72.66	258,946
	1966	364	72.19	251,385

(a) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Effective April 1, 1965, assistance ceased to be paid to the province of Quebec under this program.

TABLE 17 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966 (Concluded)

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(a)
		No.	$	$
Saskatchewan.....	1963	422	63.18	240,693
	1964	406	71.51	246,010
	1965	391	72.02	256,063
	1966	366	71.74	248,004
Alberta.....	1963	463	63.53	271,516
	1964	465	72.65	278,014
	1965	475	72.36	311,992
	1966	448	72.38	307,676
British Columbia.....	1963	547	64.04	319,457
	1964	551	73.93	335,593
	1965	556	73.15	372,208
	1966	532	73.30	358,287
Yukon Territory.....	1963	4	65.00	2,239
	1964	4	65.00	1,999
	1965	5	75.00	2,666
	1966	6	75.00	3,994
Northwest Territories....	1963	46	59.13	23,452
	1964	46	64.14	27,214
	1965	49	74.39	32,746
	1966	44	75.00	32,310
Canada.....	1963	8,634	62.50	4,881,829
	1964	8,581	68.12	4,987,897
	1965	8,586	72.10	5,624,702
	1966	5,437(b)	71.05(b)	3,632,212(b)

(a) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Excludes Quebec.

charitable, or public institution is eligible for the allowance only if the major part of the cost of his accommodation is being paid by himself or another individual. When a recipient is required to enter a public or private hospital, the allowance may be paid for no more than two months of hospitalization in a calendar year, excluding months of admission and release, but for the period that a recipient is in hospital for therapeutic treatment for his disability or rehabilitation, the allowance may continue to be paid.

As in previous years, disabilities in the two medical classes -- mental, psychoneurotic and personality disorders, and diseases of the nervous system and sense organs -- have been found to be the most prevalent among the persons becoming eligible for allowance, followed by diseases of the circulatory system. Mental deficiency, the most frequently occurring disability, accounted for over one quarter of all cases granted an allowance.

Recipients of disability allowances who are in need may receive supplementary aid under general assistance programs in the province. Where the amount of aid is determined through an individual assessment of need, which takes the recipient's requirements and resources into consideration, the federal government may share in it under the Unemployment Assistance Act.

Subsection 5 - Unemployment Assistance

Under the Unemployment Assistance Act 1956, as amended, the federal government may enter an agreement with any province to reimburse it for 50 per cent of the unemployment assistance expenditures made by the province and its municipalities to persons and their dependents who are unemployed and in need. All provinces and the two territories have signed agreements under the Act. The rates and conditions of assistance are determined by the provinces or by their municipalities. Payments to both employable and unemployable persons in need are sharable under the agreements, as are the costs of maintaining persons in homes for special care, such as nursing homes or homes for the aged. The federal government shares in additional assistance paid to needy persons in receipt of old age security pensions, old age assistance, blind persons' allowances, disabled persons' allowances, and unemployment insurance benefits, where the amount of the assistance paid is determined through an assessment of the recipient's basic requirements and of his financial resources.

TABLE 18 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(a)
		No.	$	$
Newfoundland	1963	1,436	64.61	532,852
	1964	1,586	64.53	587,092
	1965	1,746	74.63	750,279
	1966	1,817	74.49	804,197
Prince Edward Island	1963	795	64.40	311,831
	1964	801	64.47	310,817
	1965	797	74.31	360,150
	1966	788	74.25	349,881
Nova Scotia	1963	2,919	63.84	1,113,882
	1964	3,108	73.79	1,229,805
	1965	3,329	73.88	1,446,725
	1966	3,474	73.92	1,524,103
New Brunswick	1963	2,060	64.51	791,069
	1964	2,141	74.39	859,995
	1965	2,263	74.36	987,471
	1966	2,320	74.34	1,030,637
Quebec	1963	21,347	64.33	8,577,890
	1964	20,753	64.29	8,081,258
	1965	20,171	74.23	9,090,736
	1966	(b)	(b)	(b)
Ontario	1963	14,886	63.69	5,537,215
	1964	15,938	73.43	6,182,921
	1965	17,222	73.23	7,378,219
	1966	18,406	73.10	7,823,576
Manitoba	1963	1,520	64.19	577,685
	1964	1,518	74.09	615,287
	1965	1,538	73.96	679,916
	1966	1,566	73.80	688,650

(a) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Effective April 1, 1965, assistance ceased to be paid to the province of Quebec under this program.

TABLE 18 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966 (Concluded)

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(a)
		No.	$	$
Saskatchewan	1963	1,602	64.46	630,838
	1964	1,657	74.27	669,042
	1965	1,780	74.18	784,700
	1966	1,871	74.08	824,777
Alberta	1963	1,780	63.56	697,294
	1964	1,815	73.44	727,595
	1965	1,874	73.56	830,170
	1966	1,933	73.18	851,833
British Columbia	1963	2,248	64.18	853,602
	1964	2,319	74.04	929,723
	1965	2,336	73.94	1,037,484
	1966	2,385	73.86	1,061,500
Yukon Territory	1963	7	65.00	2,358
	1964	3	68.33	2,262
	1965	2	75.00	1,148
	1966	2	75.00	900
Northwest Territories	1963	21	65.00	7,797
	1964	32	65.31	10,745
	1965	45	75.00	18,435
	1966	26	74.47	19,376
Canada	1963	50,621	64.10	19,634,313
	1964	51,671	69.48	20,206,543
	1965	53,103	73.86	23,365,493
	1966	34,588(b)	73.51(b)	14,979,430(b)

(a) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Excludes Quebec.

During the year ended March 31, 1965, the federal government made payments for unemployment assistance amounting to $112,889,898. The federal share of assistance costs shown in Table 19, however, is based on payments for the months in which the assistance was actually given and, since claims may be submitted at any time within six months after the month to which they relate, the figures for each fiscal year include certain reimbursements made to the provinces after the end of that year.

Subsection 6 - Fitness and Amateur Sport

The fitness and amateur sport program began in December 1961 when the Fitness and Amateur Sport Act, administered by the Minister of National Health and Welfare, came into effect, providing up to five million dollars a year to be spent on encouragement, promotion, and development of active leisure pursuits for everyone in Canada. Although the federal, provincial, and municipal governments provide the funds and resources, the programs are carried out almost entirely by non-governmental agencies. Under the Act, Canadian participation in active recreation and amateur sport can be promoted internationally, nationally, provincially, and locally through financial assistance, technical guidance, the provision of teaching materials, assistance to training, research, and the construction of facilities.

The National Advisory Council of Fitness and Amateur Sport advises the Minister of National Health and Welfare in fitness and amateur sport matters. Its 30 members are chosen for their interest and experience, with at least one member from each province. The Council studies and evaluates progress, recommends acceptance or rejection of applications for grants, and keeps in touch with national organizations with like interests.

The federal program has five elements. Grants to National Organizations, totalling more than a million dollars a year, go to some 50 national fitness and sporting organizations to help train coaches, to improve standards of instruction, to increase participation in sports, to aid the holding of national and regional competitions, and to assist Canadian athletic teams at international competitions, such as the Olympic Games and the Commonwealth Games. Grants for Athletic Events of nation-wide interest assist the holding of such events as the 1967 Pan-American Games in Winnipeg and the 1967 Canadian Winter Games in the Quebec area. Grants for Training and Research are made for graduate study in fitness and amateur sport, for research fellowships, and for scholarships and bursaries for undergraduate study in Physical Education and Recreation. Grants are also made for research

TABLE 19 - UNEMPLOYMENT ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965

Province and year		Recipients(a) in March	Federal share of unemployment assistance costs(b)
		No.	$
Newfoundland.....	1962	59,144	4,064,063
	1963	59,199	4,218,132
	1964	59,090	4,565,680
	1965	58,931	4,620,079
Prince Edward Island...	1962	2,819	174,422
	1963	3,270	261,242
	1964	2,924	292,832
	1965	2,628	306,525
Nova Scotia.....	1962	26,200	1,673,624
	1963	28,056	1,630,551
	1964	27,565	1,798,653
	1965	26,991	1,875,679
New Brunswick.....	1962	33,841	1,526,125
	1963	39,782	1,715,372
	1964	31,114	1,743,488
	1965	24,450	1,562,799
Quebec.....	1962	253,446	31,952,317
	1963	265,612	36,274,154
	1964	253,295	39,130,901
	1965	248,334	41,877,054
Ontario.....	1962	123,923(c)	18,743,006
	1963	141,068	20,447,510
	1964	140,066	24,350,089
	1965	135,347	25,812,190
Manitoba.....	1962	32,348	4,285,123
	1963	32,579	4,526,994
	1964	31,282	4,952,050
	1965	31,446	5,203,784

(a) Includes dependents.
(b) Payment figures shown are for the months to which the claims made under the program relate and include amounts paid to the provinces by the federal government after the end of the fiscal year.
(c) Excludes persons of a class then granted aid under a mothers' allowances program.

TABLE 19 - UNEMPLOYMENT ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965 (Concluded)

Province and year		Recipients(a) in March	Federal share of unemployment assistance costs(b)
		No.	$
Saskatchewan.....	1962	44,490	4,535,334
	1963	44,227	4,777,911
	1964	41,880	4,614,614
	1965	40,600	4,578,307
Alberta.....	1962	35,136	4,445,703
	1963	44,824	6,486,669
	1964	51,048	7,981,780
	1965	60,653	9,707,440
British Columbia.....	1962	91,816	15,965,424
	1963	94,570	15,798,279
	1964	93,763	16,918,569
	1965	92,192	17,177,860
Yukon Territory.....	1962	205	39,820
	1963	292	52,496
	1964	352	67,392
	1965	322	71,509
Northwest Territories..	1962	233	33,766
	1963	685	62,849
	1964	1,110	81,926
	1965	1,179	96,672
Canada.....	1962	703,601	87,427,726
	1963	754,163	96,252,159
	1964	733,489	106,497,974
	1965	723,073	112,889,898

(a) Includes dependents.
(b) Payment figures shown are for the months to which the claims made under the program relate and include amounts paid to the provinces by the federal government after the end of the fiscal year.

into matters related to fitness, and fitness research units have been established in some universities. The Research Committee of the National Advisory Council, which is composed of leading scientists, reviews applications for aid and makes recommendations on general program policy to the Council.

Services of the Department of National Health and Welfare include the provision of technical advice, training material, and promotional aids. Visual aids for coaching, printed guides on particular sports and recreational activities, and technical information on the construction and use of facilities are being produced under the program. Typically-Canadian sporting and recreational activities have been fostered by "How To" kits that include an illustrated manual, a film to rouse interest in the subject, and films in which techniques are demonstrated. These kits and other films on sports and recreational activities are available on loan from the Department's Fitness Film Library. Committees of the National Advisory Council meet frequently with the executives of sports organizations to discuss policy. A federal-provincial committee of government officials under the chairmanship of the Deputy Minister of Welfare advises on and co-ordinates governmental aspects of the program. The Department of National Health and Welfare also co-ordinates work done by other federal agencies in fitness and amateur sport. Consultants of the Department collaborate with sports agencies, and,on request, provide advice on the planning of activities and the use of funds. Grants to the Provinces of $1 million a year are made to those that enter into cost-sharing agreements for provincial programs of fitness and amateur sports. Under the agreements the federal government meets 60 per cent of the cost of projects and the full cost of the scholarships and bursaries. Applications for all grants at the provincial or local level are made in the first instance to the responsible provincial department.

The Municipal Role. The bulk of recreational activity occurs in the individual community and municipal recreation departments co-ordinate community effort, provide continuity for voluntary organizations, and make long-range recreational plans. Thus, most ideas originate in the municipal recreation departments, where the needs of the communities are best known.

Subsection 7 - National Welfare Grants

The National Welfare Grant program, established in November 1962, is designed to help develop and strengthen welfare services in Canada. In the year ending March 31, 1967, $2,000,000 was allocated to the program, an amount scheduled to grow at the rate of $500,000 per annum until it

reaches a yearly allocation of $2,500,000. The program consists of a General Welfare and Professional Training Grant and a Welfare Research Grant. Provincial governments, municipal welfare departments, nongovernmental welfare and correctional agencies, universities, and individuals may be the ultimate recipients of grants under one or more provisions of the program. Some are financed and administered entirely by the federal government; others require application through a provincial department of welfare that actually makes the award on a cost-sharing basis with the federal government.

General welfare, bursary, training, and staff development grants are shared provisions. General welfare grants provide funds for projects to improve welfare administration, to develop provincial consultative and coordinating services, and to strengthen and extend public and voluntary welfare services in child welfare, aging, general assistance, and other welfare fields. Bursaries are provided for full-time graduate training at Canadian schools of social work, and training grants are available for employees of government and voluntary welfare agencies. Staff development grants provide support for a wide variety of staff training programs for personnel employed, or to be employed, in public and non-governmental welfare agencies.

The other provisions of the program are administered and entirely financed by the federal government. Welfare scholarships are awarded, on the basis of annual nation-wide competition, for graduate study in Canadian schools of social work. Fellowships are awarded in the same way for advanced study at Canadian and foreign universities to applicants who have demonstrated leadership qualities and ability in the fields of administration, teaching,and research in Canadian welfare. Teaching and field instruction grants assist Canadian schools of social work with the salaries of additional staff required to implement the welfare grant program.

Under the Welfare Research Grant, funds are provided for a variety of surveys, studies, and research projects undertaken by public and voluntary welfare and correctional agencies, universities, and research institutions.

The flexibility of the program was increased by policy changes made in 1966. Demonstration grants, to test new and different ways of providing services, previously given on a shared cost basis, no longer require sharing. In addition, national voluntary welfare agencies may now submit directly to the federal government projects related to the strengthening and development of welfare services not covered by other provisions of the program.

Expenditures under the program for the year ended March 31, 1966, appear in Table 20.

TABLE 20 - EXPENDITURES UNDER THE NATIONAL WELFARE GRANTS PROGRAM, BY PROVINCE, YEAR ENDED MARCH 31, 1966

Province	Research	Bursaries	Fellowships and Scholarships	Training grants	Teaching and field instruction	Staff development	Welfare services	Total
	$	$	$	$	$	$	$	$
Newfoundland	-	-	4,380	1,176	-	25,228	12,429	43,213
Prince Edward Island	-	-	-	1,500	-	-	9,771	11,271
Nova Scotia	13,175	2,500	4,219	10,604	19,238	5,705	35,460[a]	90,901
New Brunswick	-	6,671	-	2,776	-	1,749	20,374	31,570
Quebec	-	-	30,125	-	-	-	-	30,125
Ontario	44,816	30,688	27,000	8,781	103,710	59,097	188,742[a,b]	462,834
Manitoba	10,414	3,040	5,600	37,405	49,145	6,571	-	112,175
Saskatchewan	3,346	6,245	2,026	32,229	-	516	16,505[a]	60,867
Alberta	-	1,500	-	10,812	-	861	67,397	80,570
British Columbia	40,272	9,425	8,834	5,000	61,194	121	71,124[a]	195,970
Yukon Territory	-	-	-	967	-	-	11,285	12,252
CANADA	112,023	60,069	82,184	11,250	233,287	99,848	433,087	1,131,748

(a) Includes demonstration projects.

(b) Includes grant to the Vanier Institute.

Subsection 8 - Vocational Rehabilitation

The federal-provincial vocational rehabilitation program, started in 1952, was consolidated and extended under the Vocational Rehabilitation of Disabled Persons Act, 1961. Under federal-provincial agreements to share equally the costs of co-ordination, assessment, and provision of services to disabled individuals, of training personnel, and of research, the provinces have developed comprehensive programs in co-operation with existing services. Approved services comprise medical, social, and vocational assessment, counselling, restorative services, vocational training, and employment placement. They are designed to assist individuals having a substantial physical or mental disability, or other vocational handicap, to become vocationally useful in gainful employment or in the home. A provincial co-ordinator of rehabilitation is responsible for the co-ordination and administration of vocational rehabilitation services to disabled individuals in each province. In 1965-66 the provincial rehabilitation staff employed in the vocational rehabilitation programs totalled 323.

The National Co-ordinator of Rehabilitation through the Civilian Rehabilitation Branch of the Department of Manpower administers the federal aspects of this program and provides consultative services. The National Advisory Council on the Rehabilitation of Disabled Persons advises the Minister of Manpower and is composed of representatives of the provinces, employers, labour, the medical profession, national voluntary agencies, and the universities. In the year ended March 31, 1966, federal-provincial expenditures under the program (exclusive of vocational training) totalled $1,714,623. Full reports were received on 2,451 disabled persons rehabilitated during the year; before rehabilitation the majority of these persons and their dependents relied on private or public assistance for support at an estimated annual cost of $1,600,000 but following rehabilitation the estimated annual earnings by those gainfully employed was $5,600,000.

In 1958, with the establishment of the Division on Older Workers, educational efforts designed to encourage a more favourable employment climate for older workers became centred in the National Co-ordinator's office. The functions of the Division include the development of a long-range educational program; the encouragement of research; the maintenance of liaison with employer and labour organizations and voluntary agencies in Canada and other countries; and the assembly and dissemination of information. The Division is gradually becoming widely known as a central source of information on the employment problems of older persons.

The Technical and Vocational Training Assistance Act, administered by the Department of Manpower, provides for equal sharing by Canada and the provinces of the cost of approved programs for the training of disabled persons for gainful employment. During 1965-66 there were approximately 3,900 disabled persons enrolled in various courses; federal payments amounted to $799,894. Referrals for job placement are made to some 386 special services officers in 211 local offices of the National Employment Service. Special placements of handicapped persons who required assistance in finding work in 1965-66 (including those referred from provincial rehabilitation authorities) numbered 23,658.

With the integration of the federal-provincial Vocational Rehabilitation Program into the new Canada Manpower Services, vocational rehabilitation services will be increasingly extended to persons with handicaps to employability, other than physical and mental impairment.

Subsection 9 - National Council of Welfare

Co-ordination in welfare matters between different levels of government and between government and voluntary authorities is facilitated by the National Council of Welfare, an advisory body to the Minister of National Health and Welfare. The Council consists of the federal Deputy Minister of Welfare as the chairman, the provincial deputy ministers of welfare, and ten other persons appointed for three-year terms by the Governor in Council. The National Council of Welfare held its first meetings in Ottawa during April and November 1965.

Section 3 - Provincial Welfare Programs

Major welfare programs governed by provincial legislation include general assistance and social allowances, mothers' allowances, services for the aged, and child welfare services. Also, the Province of Quebec has established and is operating the Quebec Pension Plan, which is comparable to the Canada Pension Plan. Both Plans commenced in January 1966 and are to be closely co-ordinated. The nature of this social insurance program is described in more detail in the section dealing with the Canada Pension Plan (pages 53 to 58).
In most provinces responsibility for a number of the programs is shared by the provinces and their municipalities. Provincial administration of welfare services is carried out through the department of public welfare in each province; several departments have established regional offices to facilitate administration and to provide consultative services to the municipalities.

Provincial departments of public welfare are placing increasing emphasis on standards of administration and on rehabilitative services for social assistance recipients and several provinces have recently introduced legislation under which the Province will share with the municipalities the costs of preventive and rehabilitative welfare services.

The main efforts in child welfare have been directed toward improvement of standards, with particular emphasis on preventive casework services for children in their own homes, the development of specialized children's institutions, group living homes, and the finding of adoption homes for all children in need of them.

The public services are supplemented by voluntary agencies whose interests include the welfare of families and children and of groups with special needs, such as the aged, recent immigrants, youth groups, and released prisoners. Welfare councils and social planning councils contribute to the planning and co-ordinating of local welfare services. Local voluntary agencies and institutions may receive public grants, depending on the nature and standard of the services they render, although, with the exception of the semi-public children's aid societies, their main support is usually from united funds or community chests, or from sponsoring organizations.

Subsection 1 - Mothers' Allowances

All provinces make provision for allowances to needy mothers. A number of provinces combine such allowances into a broadened program of provincial allowances to persons in several categories of long-term need or have incorporated this legislation with general assistance within a single Act, while continuing separate administration. In British Columbia, on the other hand, aid is provided to needy mothers under the general assistance program on the same basis as to other needy persons. The cost of allowances to needy mothers is sharable with the Federal Government under the Canada Assistance Plan which became effective April 1, 1966 (see page 65).

Subject to conditions of eligibility which vary from province to province, mothers' allowances or their equivalents are payable to applicants who are widowed, or whose husbands are mentally incapacitated or are physically disabled and unable to support their families. They are also payable to deserted wives who meet specified conditions; in several provinces to mothers whose husbands are in penal institutions, or who are divorced or legally separated; in some, to unmarried mothers; and in Ontario, Quebec, and Nova Scotia, to Indian mothers. Foster mothers may be eligible under particular circumstances in most provinces.

The age limit for children is 16 years in most provinces, with provision made to extend payment for a specified period if the child is attending school or if he is physically or mentally handicapped. In all provinces applicants must satisfy conditions of need and residence but the amount of outside income and resources allowed and the length of residence required prior to application vary, the most common period being one year. One province has a citizenship requirement.

The number of families and children assisted in each province as at March 31, 1965, together with the amounts of benefits paid during the year are given in Table 21 and rates of benefits as at April 1966 in Table 22.

Subsection 2 - General Assistance

All provinces make legislative provision for general assistance on a means or needs test basis to needy persons and their dependents who cannot qualify for other forms of aid, and some provinces include those whose benefits under other programs are not adequate. Where necessary the aid may be for maintenance in homes for special care. Besides financial aid for the basic needs of food, clothing, shelter, and utilities, a number of provinces also provide incapacitation or rehabilitation allowances, counselling and homemaking services, and post-sanatorium care. This assistance is administered by the province or by the municipalities with substantial financial support from the province, which, in turn, is reimbursed by the federal government under the Unemployment Assistance Act for 50 per cent of the provincial and municipal assistance given (see p. 67). Under the Canada Assistance Plan, federal sharing is extended to costs of medical care and of welfare services from April 1, 1966 (see p. 65).

The provincial departments of public welfare have regulatory and supervisory powers over municipal administration of general assistance and may require certain standards as a condition of provincial aid. Length of residence is not a condition of aid in any province, but the residence of the applicant as defined by statute determines which municipality may be financially responsible for his aid. This rule does not apply in three provinces: British Columbia and Saskatchewan have equalized municipal payments and Quebec does not require its municipalities to contribute to general assistance costs. Provinces with unorganized areas take responsibility for aid in these districts. Under the federal Unemployment Assistance Act, all provinces have agreed that residence shall not be a condition of assistance for applicants who move from one province to another. For persons without provincial residence (usually a period of one year), aid may be given by the province or the municipality and a charge-back may or may not be made to the province or municipality of residence.

TABLE 21 - MOTHERS' ALLOWANCE STATISTICS, BY PROVINCE, AS AT MARCH 31, 1962 TO 1965

Province and year		Families assisted	Children assisted	Payments during the year ended March 31
		No.	No.	$
Newfoundland	1962	4,498	12,315	4,308,762
	1963	4,836	13,216	4,687,760
	1964	5,172	14,418	5,100,590
	1965	5,382	14,538	5,343,344
Prince Edward Island	1962	269	649	131,300
	1963	293	747	140,885
	1964	314	778	212,265
	1965	314	760	247,455
Nova Scotia	1962	2,754	7,452	2,258,875
	1963	2,760	7,477	2,311,725
	1964	3,331	8,100	2,533,311
	1965	3,436	8,449	2,684,337
New Brunswick	1962	2,119	6,178	1,356,078
	1963	2,165	6,287	1,347,479
	1964	2,254	6,364	2,030,948
	1965	2,284	6,282	2,089,325
Quebec	1962	19,842	52,462	19,479,716
	1963	19,531	54,638	20,743,405
	1964	19,222	54,366	22,538,118
	1965	15,785	48,076	21,067,715
Ontario	1962	10,359	25,537	13,650,401
	1963	10,175	25,522	13,913,657
	1964(a)	10,700	27,600	15,553,856
	1965(a)	12,073	31,273	17,043,696

(a) Includes dependent fathers assisted under the General Welfare Assistance Act.

TABLE 21 - MOTHERS' ALLOWANCE STATISTICS, BY PROVINCE, AS AT MARCH 31, 1962 TO 1965 (Concluded)

Province and year		Families assisted	Children assisted	Payments during the year ended March 31
		No.	No.	$
Manitoba	1962(a)	1,638	3,635	2,360,594
	1963	1,811	3,823	2,576,796
	1964	1,845	4,150	2,776,762
	1965	1,975	4,499	3,047,284
Saskatchewan	1962	2,382	5,837	2,679,587
	1963	2,459	6,158	3,512,769
	1964	2,466	6,255	3,669,427
	1965	2,461	6,276	3,811,472
Alberta	1962	1,611	3,319	1,879,195
	1963(b)	1,210	2,361	1,407,020
	1964(b)	931	1,760	1,009,867
	1965(b)	679	1,246	741,105
British Columbia(c)		...	...	...
		...	...	...
		...	...	...
Canada (d)	1962	45,477	117,384	48,104,508
	1963	45,240	120,229	50,641,496
	1964	46,235	123,791	55,425,144
	1965	44,389	121,399	56,075,733

(a) Approximate.
(b) In 1963 an additional 2,563 families with 7,542 children, in 1964 an additional 3,275 families with 9,774 children, and in 1965 an additional 4,106 families with 12,540 children were assisted under Part III of the Public Welfare Act; cost of allowances for this group is not available separately.
(c) Caseload merged with the social assistance; no separate figures are available.
(d) Exclusive of British Columbia.

TABLE 22 - MAXIMUM MONTHLY RATES OF ASSISTANCE TO NEEDY MOTHERS WITH DEPENDENT CHILDREN UNDER PROVINCIAL MOTHERS' ALLOWANCES OR EQUIVALENT PROGRAMS, APRIL 1966

Province	Mother and one child (1)	Each additional child (2)	Family maximum (3)	Supplementary (4)
Nfld.....	$95-$120 depending on place of residence. Food: Adult $25; child $10 Clothing and personal care: Adult $15; child $5 Fuel: $15 Rent: $25 (rural); $50 (urban) $25 a month for a child living with a guardian	Food: $10 Clothing: $5	None set	Up to $50 a month may be granted under special circumstances.
P.E.I.....	$75	$10	None set	None granted.
N.S.....	None set	None set	$90	None granted.
N.B.....	$60	$10	$115	$10 for rent if necessary and if allowance paid is below the maximum.
Que.....	$95	$20	None set	A supplementary allowance according to need may be granted.
Ont.....	$156.95-$162.95 depending on age of child Pre-added budget (food, clothing, household sundries): $63.45-$69.45 depending on age of child Shelter: $76.50 (unheated); $85 (heated) Fuel: up to $32 (Sept.-March; Sept.-April in territorial districts) $40 for one foster child living with a foster mother	Depending on age of child: $17.70-$23.70 for second child $19-$25 for 3rd child $18-$24 for 4th child Additional amounts are allowed as follows: each girl 13-19 years, $3 each boy 13-15 years, $5 each boy 16-19 years, $8 $75 for two foster children $25 for each additional foster child	$300	An increase in the amount of the pre-added budget may be made for special diets on medical recommendation.

TABLE 22 - MAXIMUM MONTHLY RATES OF ASSISTANCE TO NEEDY MOTHERS WITH DEPENDENT CHILDREN UNDER PROVINCIAL MOTHERS' ALLOWANCES OR EQUIVALENT PROGRAMS, APRIL 1966
(Continued)

Province	Mother and one child (1)	Each additional child (2)	Family maximum (3)	Supplementary (4)
Man.....	$115.50-$127.50 (exclusive of fuel allowance) depending on age of child Food: Adult $20; child 12-17 years, $21; child 7-11 years, $17; child 4-6 years, $13; child birth-3 years, $11; added for household of two:$3 Clothing: Adult $5; child 12-17 years, $6; child 7-11 years, $5; child birth-6 years, $4 Rent: up to $55 Utilities: up to $7.50 Household and personal needs: $10 Fuel: (Oct.-May inclusive) up to $20	$15-$27 depending on age of child. Rates for food and clothing as in Column (1)	None set	An allowance of up to $150 a year may be granted for special needs. An additional amount of $7 a month may be allowed for utilities and an additional grant of up to $50 may be made at the end of the winter fuel season. $10 a month may be added for rent if necessary.
Sask.....	$118.95-$134.15 depending on age of child Food: Adult $21.50; child pre-school, $12; child 6-11 years, $17; child 12-15 years, $21; child 16-18 years, $23; added for household of two: $1. Clothing: Child birth-5 years, $5; child 6-11 years, $6.80; child 12-15 years, $7.50; child 16-18 years, $8; person 19 years and over, $10. Necessities for Personal Care: Adult $1.60; child pre-school, $0.40; child 6-11 years, $0.80; child 16-18 years,$1.60 Household Allowances $1.30 Rent: $40 Fuel: up to $15.15 Utilities: up to $11	$17.40-$34.60 depending on age. Rates for food, clothing, and personal care as in Column (1)	None set	Special food allowance may be granted on medical recommendation.

TABLE 22 - MAXIMUM MONTHLY RATES OF ASSISTANCE TO NEEDY MOTHERS WITH DEPENDENT CHILDREN UNDER PROVINCIAL MOTHERS' ALLOWANCES OR EQUIVALENT PROGRAMS, APRIL 1966
(Concluded)

Province	Mother and one child (1)	Each additional child (2)	Family maximum (3)	Supplementary (4)
Alta. 1/ ...	Food: Mother $22.50; child, $12.60-$30.20 depending on age and sex Clothing: Mother $8.80; child, $4.20-$10.50 depending on age and sex Rent, fuel, utilities: according to community standards	$16.80-$40.40 depending on age and sex of child	None set	An increase in the food allowance may be granted on medical recommendation.
B.C. 2/ ...	$125 Food: $60 Clothing, fuel, operating and sundries: $20 Shelter: $45	$25	$250 2/	An additional allowance may be granted in special circumstances.

1/ Under the Mothers' Allowances program, the rate for a mother and one child is $80 a month. However, since 1961 all applications for assistance for needy mothers with dependent children come under the Public Welfare Act with rates as indicated above. Recipients under the Mothers' Allowances Act in 1961 were permitted to transfer to the new program if they so wished.

2/ Social assistance rates. The mothers' allowances program has been amalgamated with the social assistance program.

The formula for provincial-municipal sharing of costs is determined by the province. In Newfoundland, general assistance is the responsibility of the province and is administered by the Department of Public Welfare. In Prince Edward Island, the Department of Welfare and Labour provides direct social assistance in rural areas and assumes 75 per cent of the cost of assistance granted by the City of Charlottetown and the incorporated towns and villages; aid to needy families where the breadwinner is suffering from tuberculosis is borne entirely by the province. However, the Welfare Assistance Act assented to April 7, 1966 to be effective on proclamation authorizes assistance for persons in need to be paid from provincial funds. In Nova Scotia, assistance is administered by the municipality, which receives reimbursement from the Department of Public Welfare for two-thirds of the cost of the aid provided and one-half of the cost of administration; allowances for certain disabled persons are administered by the province. In New Brunswick, the province reimburses each municipality to the extent of one dollar per capita of the population plus 70 per cent of expenditures on general assistance in excess of that amount, and also pays 50 per cent of the cost of administration. The full responsibility for financing the assistance program will, however, be assumed by the province when the Social Welfare Act of 1966 is proclaimed.

In Quebec, the Department of Family and Social Welfare reimburses authorized agencies and municipal departments for the full cost of aid to persons in their own homes. It takes full responsibility for aid to persons who are unfit for work for at least 12 months, for supplementary allowances and allowances to needy widows and spinsters 60-65 years of age. The cost of aid to unemployable persons in homes for special care, including nursing homes, is borne two-thirds by the province and one-third by the institution.

In Ontario, the Department of Public Welfare reimburses municipalities up to a prescribed maximum for 80 per cent of their expenditures for general welfare assistance, and for 90 per cent of expenditures for aid to persons in excess of a given proportion of the population in the municipality. Aid for rehabilitation services and aid on behalf of foster children, for which the municipalities are reimbursed 50 per cent, are excluded in these calculations. The province administers allowances to needy widows and unmarried women 60 years of age or over. Since November 1965, the province has reimbursed counties and municipalities for 50 per cent of salaries paid to staff employed full time in the administration of welfare services, and 50 per cent of travelling expenses related to the administration of welfare services.

In Manitoba, the province administers aid to mentally or physically incapacitated persons whose disability is likely to last more than 90 days, and to persons unable to work because of their age. Aid to other needy persons, termed indigent relief, is the responsibility of the municipalities, which are reimbursed through the provincial Department of Welfare to the extent of 40 per cent of the costs, or at a higher rate if costs exceed a specified amount. In Saskatchewan, through the Department of Welfare, the province reimburses the municipalities for approximately 95 per cent of the cost of assistance granted to needy persons. In Alberta, the province reimburses the municipalities for 80 per cent of the value of the assistance given and since April 1, 1966, for 80 per cent of the costs of administration and of certain preventive social services. The provincial Department of Public Welfare has full responsibility for allowances payable to persons who are mentally or physically handicapped for a period likely to last for more than 90 days, and to persons who because of their age are not able to be self-supporting. The Department maintains two hostels and one welfare centre to care for unemployable single homeless men without municipal domicile.

British Columbia, through its Department of Social Welfare, reimburses the municipalities on a pooled basis for 90 per cent of the total cost of social assistance to needy persons. Also, the province shares equally with the municipalities expenditures on salaries of social workers; a municipality with fewer than 15,000 persons may arrange to have the Department undertake social work within the municipality and reimburse it at the rate of 60 cents per capita per year.

Subsection 3 - Living Accommodation for Elderly Persons

In all provinces, homes for the aged and infirm are provided under provincial, municipal, or voluntary auspices. Voluntary homes generally are provincially inspected in accordance with prescribed standards and in some provinces must be licensed. Most provinces contribute to the maintenance of needy persons in homes for the aged, either through general assistance or through statutes that relate particularly to these homes. Also, 50 per cent of the payments on behalf of assistance cases in homes for the aged and infirm (homes for special care) are met by the federal government (see p. 71).

Several provinces make capital grants toward the construction of homes, and in five provinces capital grants are also available to municipalities, voluntary organizations, or limited-dividend companies for the construction of low-rental housing.

Newfoundland maintains a home for the aged and infirm at St. John's and pays part or all of the cost of maintaining needy old people in homes for the aged and boarding homes. Provision is made for grants to organizations constructing homes for the aged. The province is authorized by the Senior Citizens (Housing) Act, 1960 to guarantee the repayment of loans made under the National Housing Act to limited-dividend companies constructing hostels or housing for the elderly and to guarantee the cost of operating such projects. The aged and infirm in Prince Edward Island are cared for in two institutions operated by the Department of Welfare and Labour. In Nova Scotia, the aged are cared for in municipal or county homes, in homes operated by religious or private organizations, and in private boarding homes. The province reimburses the municipalities for two-thirds of their expenditures for the maintenance of needy persons in municipal homes, subject to compliance with specified standards of care and accommodation. Homes for the aged receiving aid from the provincial government are subject to provincial inspection. In New Brunswick provincial grants may be made under the Senior Citizens Housing Act to assist limited-dividend housing corporations in constructing and equipping low-rental housing units for senior citizens. Homes for the aged are operated under municipal, religious, fraternal, and private auspices and receive no direct financial support from the province. Voluntary and proprietary homes are subject to provincial licensing and inspection and must meet standards contained in regulations under the Health Act. Under the Social Assistance Act, 1960, the province contributes to the maintenance of needy persons in municipal homes.

Institutional care for indigent old people in Quebec is provided through charitable institutions under the Public Charities Act. The Homes for the Aged Act authorizes the province to erect and maintain homes for the aged and housing projects, or to make grants to voluntary organizations for this purpose. Standards in homes are governed by regulations under the Public Health Act.

Under the Ontario Homes for the Aged Act, municipalities must provide institutional or boarding-home care for the aged. The province contributes 50 per cent of the costs of construction of approved homes and 70 per cent of their net operating and maintenance costs. It also pays up to 70 per cent of the costs of maintenance in approved boarding homes. Homes for the aged under voluntary auspices are approved, inspected, and assisted under the Charitable Institutions Act, which provides for grants in aid of construction equalling 50 per cent of costs up to $2,500 per bed and maintenance grants of 75 per cent of the amount spent by the organization up to $6.00 per day for each resident where the institution maintains a bed-care unit of 20 beds and $4.00 where it does not. The Elderly Persons Housing Aid Act provides for grants to limited-dividend housing corporations building low-rental housing for elderly persons.

Institutions and boarding homes for the aged and infirm in Manitoba are supervised and licensed by the Department of Health under public health legislation. Under the Elderly and Infirm Persons Housing Act, the province makes construction grants to municipalities and charitable organizations equalling one-third of the costs of constructing or of acquiring and renovating housing accommodation and homes for the aged. Grants may not exceed $1,700 for one-person housing units, $2,150 for two-person housing units, $2,000 per bed for new homes for the aged, and $1,000 per bed for homes that have been renovated. Under the Social Allowances Act, 1959, the province bears the entire cost of assistance to those who, because of age or incapacity, require care for more than 90 days by another or in a home for the aged.

Aged and infirm persons in Saskatchewan are cared for in five provincial geriatric centres and in municipal, voluntary, and proprietary homes for the aged. The latter are inspected and licensed under The Housing and Special-care Homes Act. This Act also empowers the province and municipalities to subscribe to the capital stock of limited-dividend housing companies building low-rental accommodation for older persons; the province may also make loans to municipalities to assist them in subscribing. Also, the province may guarantee the costs of operation of hostel-type accommodation with common dining and sitting rooms for aged single persons. Capital grants amounting to 20 per cent of construction costs and annual maintenance grants of $40 for each self-contained housing unit and $60 for each bed in a special-care home (that is, a nursing home, supervisory care home, or sheltered care home) may be made to municipalities, churches, or charitable organizations sponsoring approved homes or housing projects. Costs of maintaining needy persons in homes for the aged are shared by the province and the municipalities under the Social Assistance Act.

Under what are termed 'master agreements', Alberta bears the cost of constructing and equipping homes for the aged and housing units on municipal land. Projects are operated by provincially incorporated foundations which include municipal councilmen in their membership; net costs of operation are borne by the municipalities. The province also meets up to 80 per cent of the cost incurred by municipalities for the maintenance of elderly persons in housing projects and municipal or private homes. Private homes are municipally licensed.

British Columbia operates a home for elderly homeless men, a provincial infirmary for the chronically ill, and, for senile and psychotic patients, three provincial homes for the aged. It also licenses and supervises homes for the aged and boarding homes and, where necessary, shares with the municipalities on a 90-10 basis the cost of maintaining needy residents. Under the Elderly Persons Housing Aid Act, the

province makes grants amounting to one-third of construction costs to municipalities and nonprofit corporations, including religious and service organizations, engaged in building homes or low-rental housing units for elderly citizens.

Subsection 4 - Recreational Centres for Elderly Persons

Ontario has given an impetus to the provision of recreation centres for the elderly through the passing in 1962 of the Elderly Persons Social and Recreational Centres Act. This Act provides for a provincial grant of up to 30 per cent of the cost of constructing or buying a building for use as a centre if the municipality contributes 20 per cent.

Subsection 5 - Child Welfare Services

Child welfare services, which include child protection and care, services for unmarried parents, and adoption services, are provided in all provinces under provincial legislation and are administered by a division of child welfare within the provincial department of welfare. The program may be administered by the provincial authority or the responsibility may be delegated to local children's aid societies, that is, to voluntary agencies with boards of directors, operating under charter and under the general supervision of provincial departments; in Quebec, child welfare services are administered by recognized voluntary agencies and institutions, religious and secular. In Newfoundland, Prince Edward Island, Saskatchewan, and,to a large extent, in Alberta, they are administered by the province; in the larger urban centres of Alberta there is some delegation of authority to the municipality. In Ontario and New Brunswick, a network of local children's aid societies, operating under statutory authority, is responsible for the services. In Nova Scotia, Manitoba, and British Columbia, services are administered by local children's aid societies in the heavily populated areas and by the province in other areas.

Children's aid societies and the recognized agencies in Quebec receive substantial provincial grants and sometimes municipal grants and in many areas they also receive support from private subscriptions or from community chests or united funds. Maintenance costs for children in care of a voluntary or public agency may be borne by the province -- as in Alberta, Saskatchewan, Manitoba, Prince Edward Island, and Newfoundland -- or partly by the municipality of residence and partly by the province. Since April 1, 1966, these costs have been sharable with the Federal Government under the Canada Assistance Plan, which also provides for federal sharing in costs of welfare services (see p. 65).

The child welfare agencies, provincial or private, have the authority to investigate cases of alleged neglect and, if necessary, to apprehend a child and to bring the case before a judge upon whom rests the responsibility of deciding whether in fact the child is neglected. When neglect is proven, the court may direct that the child be returned to his parent or parents, under supervision, or be made a ward of the province or a children's aid society or, in Quebec, be placed under the authority of a suitable person or agency, whose services may involve casework with families in their own homes, care in foster boarding homes or in adoption homes, or in selected institutions. Children placed for adoption may be wards or they may be placed on the written consent of the parent. Adoptions, including those arranged privately, number about 14,000 annually.

Child welfare agencies make use of the small selective institution for placement of children who are forced to be away from their own homes for a short period or who may need preparation for placement in foster homes, and emphasis is increasingly being placed on group-living homes. The development of small, highly specialized institutions, which function as treatment centres for emotionally disturbed children, is of particular significance. Institutions for children are governed by provincial legislation and by provincial or municipal public health regulations. The institutions are generally subject to inspection and in some provinces to licensing. Sources of income may include private subscriptions, provincial grants, and maintenance payments on behalf of children in care, payable by the parents, the placing agency, or the responsible municipal or provincial department.

Services to unmarried parents include casework services to the mother and possibly to the father, legal assistance in obtaining support for the child from the father, and foster-home care or adoption services for the child. Support for unmarried mothers may be obtained under general assistance programs. In many centres, homes for unmarried mothers are operated under private or religious auspices.

Day nurseries for the children of working mothers are established only in the larger centres. These are chiefly under voluntary auspices, except in Ontario where there are also municipally sponsored day nurseries operated with the aid of provincial grants.

Section 4 - International Welfare

Canada's participation in the international welfare activities of the United Nations and its Specialized Agencies and of other international organizations is co-ordinated by the Department of National Health and Welfare.

Canada has been on the Executive Board of the United Nations Children's Fund (UNICEF) since the Fund was created in 1946, except for a three year period from 1959 to 1961. The Deputy Minister of National Welfare, the Canadian representative on the Executive Board of UNICEF, was elected Chairman of the Board in February 1966 after serving two consecutive terms as Chairman of its Programme Committee. Some 224 UNICEF-assisted projects are presently benefitting the health, education and welfare of needy children in 84 developing countries and territories. Canada is also represented on the Economic and Social Council of the United Nations and on the Governing Body of the International Labour Organization. The United Nations and its Agencies are assisted by the completion of questionnaires and the preparation of reports as well as by Canadians serving as experts or advisors.

Through multilateral and bilateral programs, Canada contributes technical assistance to developing countries in the social as well as in other fields. Academic training and observation tours are arranged for foreign students in Canadian universities and institutions and Canadian welfare experts are sent abroad to help in the social development of less advanced nations.

In addition to these activities and contributions by the Canadian government, Canadian voluntary agencies are also active in providing aid to developing countries and participating in international discussions of welfare matters.

PART III - HEALTH AND SOCIAL WELFARE EXPENDITURES

Section 1 - Government Expenditures on Health and Social Welfare

In the seven years ended March 31, 1959-65, expenditures of all levels of government on health and social welfare grew from $2,821 million to $4,466.5 million, an increase of 58 per cent. If these figures are adjusted in order to take account of the growth in population, the increase in per capita expenditures, from $164 to $231, is about 41 per cent. Government expenditures may also be measured in relation to major economic indicators; on this basis, government expenditures on health and social welfare rose over the 1959-65 period from 11.1 to 12.5 per cent of net national income and from 8.4 to 9.3 per cent of gross national product. The federal share of health and social welfare expenditures fell from 73.9 per cent in 1958-59 to 66.4 per cent in 1964-65. Over the same period the provincial share rose from 22.2 to 30.7 per cent, and the municipal outlays declined from 3.9 per cent to 2.9 per cent.

Of considerable interest is the growing proportion of government expenditures on health and social welfare taken up by health programs; in 1958-59 such programs accounted for $624 million or 22 per cent and in 1964-65 for $1,573 million or almost 35 per cent.

An outline of the principal components for 1964-65 shows the magnitude of the major programs and services - family allowances payments amounted to $546 million, old age security payments to $885 million, unemployment insurance benefits to $335 million, veterans' pensions and allowances to $180 million and $93 million, respectively, and payments from the Prairie Farm Emergency Fund to $11 million. These income-maintenance programs were entirely the responsibility of the federal government.

In addition, payments under the new Youth Allowances program, which commenced in September 1964, amounted to $27,000,000. The province of Quebec had instituted a program of Schooling Allowances three years prior to the introduction of the federal program. This necessitated a special arrangement with Quebec whereby that province continued its program, but with appropriate fiscal arrangements with the federal government.

Federal-provincial income maintenance programs required expenditures of $90 million on old age assistance, $7.5 million for blindness allowances, nearly $47 million for disabled persons' allowances, and $215 million for unemployment assistance, the latter figure including some municipal expenditure. Effective April 1, 1965 Quebec withdrew from these federal-provincial programs under the Established Programs (Interim Arrangements) Act which entitles that Province to a tax abatement as an equalization payment. Workmen's Compensation Boards spent $120 million on cash benefits for pensions and compensation.

Welfare services for Indians and for veterans and the national employment service accounted for approximately $60 million at the federal level and child welfare services required an expenditure of approximately $60 million by provincial governments.

In the field of health, federal grants to the provinces under the Hospital Insurance and Diagnostic Services Act totalled almost $434 million and grants for hospital construction and general health grants to the provinces and municipalities amounted to $57 million. The Federal Government spent $31 million on its Indian and Northern Health Services and $47 million on hospital and treatment services for veterans. Provincial expenditures on hospital care are estimated to have totalled $740 million; in addition, $100 million was spent on other health services. Workmen's Compensation Boards paid $54 million for medical aid and hospitalization. Municipal governments spent $81 million on health.

Section 2 - Expenditures on Personal Health Care

Expenditures made in Canada on personal health care services, shown in Table 25, include for the purposes of this section the amounts spent by hospitals and the amounts received by physicians, dentists, pharmacists for prescription services, and other paramedical professionals, in the provision of health care and treatment directly to individuals.

No attempt is made to include expenditures on public health, or public or private capital expenditures such as the building or extension of hospitals or other health facilities. Also excluded are the cost of administration of public health programs and other technical services as well as the cost of administering voluntary profit or nonprofit health insurance plans. On the other hand, expenditures by the three levels of government on behalf of individuals are included.

TABLE 23 - GOVERNMENT EXPENDITURES ON HEALTH AND SOCIAL WELFARE: TOTAL AMOUNT, PER CAPITA AMOUNT, AND PERCENTAGE DISTRIBUTION, BY LEVEL OF GOVERNMENT, FISCAL YEARS 1958-59 TO 1964-65

Fiscal year	Federal	Provincial	Municipal	Total
	Expenditures (millions of dollars)			
1958-59	2,084.7	627.4	109.3	2,821.3
1959-60	2,162.2	754.7	106.4	3,023.3
1960-61	2,359.9	885.7	109.0	3,354.6
1961-62	2,575.8	998.1	107.8	3,681.8
1962-63	2,682.3	1,082.7	117.3	3,882.2
1963-64	2,799.7	1,164.4	123.0	4,087.1
1964-65	2,967.7	1,369.8(a)	129.0(a)	4,466.5(a)
	Per capita expenditures (dollars)			
1958-59	121.53	36.57	6.37	164.47
1959-60	123.20	43.00	6.06	172.27
1960-61	131.28	49.27	6.06	186.62
1961-62	140.32	54.37	5.87	200.57
1962-63	143.57	57.95	6.28	207.79
1963-64	147.26	61.25	6.47	214.98
1964-65	153.28	70.75	6.66	230.69
	Percentage distribution			
1958-59	73.9	22.2	3.9	100.0
1959-60	71.5	25.0	3.5	100.0
1960-61	70.4	26.4	3.2	100.0
1961-62	70.0	27.1	2.9	100.0
1962-63	69.1	27.9	3.0	100.0
1963-64	68.5	28.5	3.0	100.0
1964-65	66.4	30.7	2.9	100.0

(a) Estimated.

TABLE 24 - EXPENDITURES OF ALL LEVELS OF GOVERNMENT ON HEALTH AND SOCIAL WELFARE IN RELATION TO NET NATIONAL INCOME AND GROSS NATIONAL PRODUCT, FISCAL YEARS 1958-59 TO 1964-65

Fiscal year	Government expenditures on health and social welfare		
	Amount	Per cent of net national income	Per cent of gross national product
	(millions of dollars)		
1958-59	2,821.3	11.1	8.4
1959-60	3,023.3	11.3	8.5
1960-61	3,354.6	12.2	9.2
1961-62	3,681.8	12.8	9.7
1962-63	3,882.2	12.6	9.5
1963-64	4,087.1	12.3	9.3
1964-65	4,466.5(a)	12.5	9.3

(a) Estimated figures.

Canadians spent an estimated $2,194 million in 1964 on personal health care, which is two and a half times the $870 million they spent in 1955. The year-to-year rates of increase during that period varied from 8.0 per cent in 1962 to 13.6 per cent in 1956, their average being 10.8 per cent. The per capita expenditure, which was $55.40 in 1955, rose to $105.73 in 1963 and an estimated $114.04 in 1964. The population increase during the period was 22.8 per cent.

The proportion of the gross national product represented by expenditures on personal health care was 3.2 per cent in 1955 and 4.7 per cent in 1964. Thus, one in every 21 dollars of production in Canada in 1964 was for personal health care goods and services as compared with one in every 34 dollars nine years previously.

Payments received by physicians and surgeons for providing personal medical care services comprise about 23 per cent of total expenditures on personal health care, and were $493,900,000 in 1964.

Section 3 - Earnings of Privately Practising Physicians in Canada

More than 98 per cent of the earnings of privately practising physicians and surgeons in Canada were obtained from fees charged for individual items of professional service. As Table 26 shows, average gross earnings in 1964 from fees plus wages and salaries earned incidental to fee practice were $30,409.

This figure was 7 per cent higher than in 1963 and 47 per cent above the 1957 figure. The average annual rate of increase over the period from 1957 to 1964 was 5.6 per cent. The highest gross earnings in 1964 were reported in Saskatchewan, at $36,484. In Ontario, Alberta, and British Columbia they were above the national average. Average gross incomes in the remaining provinces ranged downward from $27,922 in Manitoba to $23,088 in Newfoundland.

Generally, throughout the eight-year period 1957-1964, highest average gross earnings have been most consistently reported in Ontario and the western-most provinces, with Saskatchewan having the highest average after 1962.

The net returns to doctors, after deduction of the expenses of professional fee practice, reveal mainly similar geographic patterns, as seen in Table 27. Net earnings for Canada as a whole averaged $20,374 in 1964. This figure was 10 per cent higher than in 1963 and about 59 per cent above the 1957 figure. The average yearly rate of increase was 6.9 per cent.

TABLE 25 - EXPENDITURES ON PERSONAL HEALTH CARE[a], CANADA, 1955-1964

Year	Hospital services					Physicians' services	Prescribed drugs (e,f)	Dentists' services	Other (f,g)	Total
	Active treatment(b)	Mental(c)	Tuber-culosis(c)	Federal(d)	All hospitals					
	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000
1955	342.4	68.9	29.9	38.8	480.0	206.5	59.5	68.6	55.0	869.6
1956	380.8	77.6	30.6	40.8	529.8	240.1	71.8	81.5	65.0	988.2
1957	422.9	87.5	31.0	45.3	586.7	271.0	84.5	87.3	70.0	1,099.5
1958	462.3	99.0	30.4	48.4	640.1	300.5	90.3	98.1	85.0	1,214.0
1959	542.6	111.6	29.6	50.3	734.1	324.7	106.5	100.1	95.0	1,360.4
1960	625.2	120.2	30.1	53.9	829.4	353.9	107.3	112.4	105.0	1,508.0
1961	714.8	132.8	29.9	56.8	934.3	387.1	111.4	118.8	115.0	1,666.6
1962	802.4	141.7	29.5	60.1	1,033.7	404.6	113.1	123.8	125.0	1,800.2
1963	899.7	158.9	28.4	62.9	1,149.9	451.7	126.5	134.8	135.0	1,997.9
1964(f)	993.7	180.0	27.0	65.9	1,266.6	493.9	136.0	152.0(h)	145.0	2,193.5

(a) Excluding expenditures on public health and for capital purposes.
(b) Including gross expenditures of public and private acute, chronic, and convalescent hospitals in 1955-1957 and, in non-participating provinces, in 1958-1960; including gross expenditures of budget review and contract hospitals in 1961-1964 and, in participating provinces, in 1958-1960; excluding expenditures of mental, tuberculosis, and federal hospitals.
(c) Including gross expenditures of public and private hospitals; excluding expenditures of federal hospitals.
(d) Including acute, chronic, convalescent, mental, and tuberculosis hospitals of the Department of National Health and Welfare and the Department of Veterans Affairs; excluding hospitals of the Department of National Defence.
(e) Sold by retail drugstores only.
(f) Estimated.
(g) Including expenditures for services of private duty nurses, and chiropractors, osteopaths, and optometrists; excluding all employees of hospitals.
(h) Estimate calculated on a new basis and not necessarily comparable with figures for earlier years.

TABLE 26 - AVERAGE GROSS PROFESSIONAL EARNINGS[(a)] OF PHYSICIANS, CANADA BY PROVINCE, 1957 TO 1964

	1957	1958	1959	1960	1961	1962	1963	1964
	$	$	$	$	$	$	$	$
Newfoundland	18,178	19,199	19,289	21,741	20,945	19,379	21,288	23,088
Prince Edward Island	15,517	17,809	18,854	20,177	20,001	19,676	23,413	23,157
Nova Scotia	19,640	19,667	21,341	22,802	23,242	23,302	23,455	25,739
New Brunswick	18,413	19,538	18,918	22,523	24,220	23,978	26,376	27,802
Quebec	16,887	18,264	18,721	19,656	22,118	23,418	25,748	26,813
Ontario	22,003	23,415	24,153	25,534	27,206	27,779	30,641	33,201
Manitoba	22,782	24,106	26,436	24,751	27,897	27,774	27,509	27,922
Saskatchewan	22,689	23,511	23,699	27,102	27,103	23,238	35,657	36,484
Alberta	23,368	24,828	25,254	28,032	29,221	31,187	30,912	32,690
British Columbia	23,736	24,909	26,628	28,066	27,867	27,498	27,670	30,510
Canada	20,721	22,014	22,811	24,174	25,733	26,180	28,523	30,409

(a) Professional gross income, including incidental wages and salaries; these data are completely revised and supersede material published in earlier editions.

TABLE 27 - AVERAGE NET PROFESSIONAL EARNINGS[a] OF PHYSICIANS, CANADA BY PROVINCE, 1957 TO 1964

	1957	1958	1959	1960	1961	1962	1963	1964
	$	$	$	$	$	$	$	$
Newfoundland	13,599	14,012	13,970	15,961	15,120	14,753	15,653	16,981
Prince Edward Island	9,787	10,237	11,427	12,589	13,119	15,448	15,777	16,478
Nova Scotia	10,026	12,862	14,820	16,074	16,070	15,925	15,839	17,851
New Brunswick	10,023	12,409	12,372	15,535	16,288	16,418	17,701	19,255
Quebec	10,669	11,136	11,795	12,870	14,454	15,173	16,696	18,534
Ontario	13,914	14,993	15,605	16,754	17,682	18,306	20,492	22,247
Manitoba	12,985	13,566	14,800	15,338	15,148	15,998	17,320	17,879
Saskatchewan	13,900	14,527	15,096	15,955	15,843	14,619	21,625	23,879
Alberta	13,422	14,815	15,941	17,754	17,925	18,612	19,111	21,117
British Columbia	14,926	15,488	16,953	17,600	17,067	17,284	17,464	19,560
Canada	12,812	13,729	14,537	15,671	16,397	16,888	18,590	20,374

(a) Professional gross fee income less expenses of practice, plus incidental salaries and wages; these data are completely revised and supersede material published in earlier editions.

In 1964 the highest provincial average net income from professional practice was reported by Saskatchewan doctors. The figure was $23,879. The second highest figure for 1964 was in Ontario, at $22,247. Lowest net incomes were reported in Prince Edward Island, at $16,478, Newfoundland, at $16,981, Nova Scotia, at $17,851, and Quebec, at $18,534.

Section 4 - Number of Physicians in Canada

There were 21,011 active civilian physicians in Canada in 1962 according to a survey conducted by the Department of National Health and Welfare, giving a ratio of 881 persons per physician for Canada as a whole. Table 28 gives the provincial distribution of the 1962 data and shows also the historical trends for Canada. The ratio of 748 persons per physician for British Columbia in 1962 is the most favourable level of physician-supply yet achieved by a Canadian province. For Canada as a whole, the 1962 level of 881 persons per physician continues the post-war trend of improvement of overall physician supply.

TABLE 28 - ACTIVE CIVILIAN PHYSICIANS AND POPULATION PER PHYSICIAN, CANADA AND PROVINCES, 1962, AND CANADA, SELECTED YEARS, 1901-62

Province	Active civilian physicians, 1962		Year	Active civilian physicians	
	Number	Population per physician		Number	Population per physician
Newfoundland	304	1,539	Census data:		
Prince Edward Is.	87	1,218	1901	5,475	972
Nova Scotia	735	1,012	1911	7,411	970
New Brunswick	458	1,321	1921	8,706	1,008
Quebec	5,932	902	1931	10,020	1,034
Ontario	7,826	808	1941	10,723	1,072
Manitoba	1,085	859	Register of		
Saskatchewan	919	1,010	Physicians,		
Alberta	1,367	998	DNH&W:		
British Columbia	2,210	748	1951	14,163	989
Yukon & N.W.T.	25	1,560	1954	15,651	977
			1959	19,300	906
Canada	21,011(a)	881	1962	21,011	881

(a) Includes 63 not allocated by province.

From Table 29 it is seen that the physicians of Canada are more highly concentrated in the larger centres of population than is the population generally, and that this concentration has been increasing for both the total population and physicians. In addition, the percentage increase of the 1962 total of physicians in centres of less than 10,000 population over that for 1951 was less (5.8) than the percentage increase over 1951 of the 1959 total in these areas (11.9), indicating a decrease in the total number of physicians in these areas during the 1959-62 period. Even though the trends indicated in these data are slightly exaggerated by changes between Censuses in the make-up of census metropolitan areas, it is clear that the overall trend is toward widening of the traditional disparity in availability of physician services between smaller localities and large urban centres.

TABLE 29 - PER CENT OF POPULATION AND OF ACTIVE CIVILIAN PHYSICIANS IN CENTRES OF A) 10,000 POPULATION OR OVER, AND B) LESS THAN 10,000 POPULATION, SHOWING PER CENT INCREASE OF POPULATION AND PHYSICIANS OVER 1951

Item	Per cent of total			Per cent increase over 1951		
	In centres of:		Total	For centres of:		Total
	10,000 or more(a) population	Less than 10,000 population		10,000 or more(a) population	Less than 10,000 population	
Population:						
1961	57.7	42.3	100.0	55.9	6.3	30.2
1951	48.2	51.8	100.0	..	..	..
Physicians:						
1962	81.0	19.0	100.0	64.6	5.8	48.8
1959	78.2	21.8	100.0	46.8	11.9	37.4
1954	73.7	26.3	100.0	12.3	9.3	11.5
1951	73.2	26.8	100.0	..	..	..

(a) Includes all parts of Census metropolitan areas, regardless of size; size of place for 1962 physicians as in 1961 Census; for 1959 as in 1956 Census; for 1954 and 1951 as in 1951 Census.

Table 30 indicates little real change in recent years in the proportion of active civilian physicians who are engaged primarily in private practice, but an increased emphasis on specialization is indicated within both the private practice and "other work" groups. The increase between 1959 and 1962 in the proportion of physicians who were "interns, residents, fellows" is in line with the trend toward increased specialization and the longer training period involved.

TABLE 30 - PER CENT DISTRIBUTION OF ACTIVE CIVILIAN PHYSICIANS BY NATURE OF MAJOR WORK IN WHICH ENGAGED, 1962, 1959 AND 1954

Nature of major work	1962 (estimate)	1959 (estimate)	1954
	per cent	per cent	per cent
General private practice[a]	37.7	39.3	43.2
Specialist private practice[a]	35.7	34.7	29.1
Total, private practice[a]	73.4	74.0	72.3
Interns, residents, fellows	9.0	8.3	8.3
Other work: Non-specialist	4.7	5.7	8.5
Specialist	12.9	12.0	10.8
Total[b]	100.0	100.0	100.0

(a) Includes group practice and partnerships.
(b) May not total exactly because of rounding.

Note: Data prior to 1959 did not take into account certifications by the College of Physicians and Surgeons of the Province of Quebec. Although designation as a "specialist" did not depend on the holding of formal specialist qualifications, specialization was nevertheless slightly understated in the data prior to 1959, most particularly in Quebec Province.

PART IV - NATIONAL VOLUNTARY HEALTH AND WELFARE ACTIVITIES

A number of national voluntary agencies carry on important work in the provision of health and welfare services, medical research, and education. These agencies, some of which are described below, supplement the services of the federal and provincial authorities in many fields, and play a leading role in stimulating public awareness of health and welfare needs and in promoting action to meet them.

The Canadian Welfare Council. - The Council, established in 1920, is a national voluntary association of English-speaking and French-speaking organizations and individual citizens whose aim is the advancement of social welfare in Canada. Member organizations include community funds and councils, other private social agencies, various federal, provincial, and municipal departments, and citizen groups and individuals active in the fields of health, welfare, and recreation. It furnishes authoritative information, technical consultation, and field service in the main areas of social welfare and provides a means of co-operative planning and action by public and private agencies.

The policies and programs of the Council are determined by its members under the leadership of a nationally representative board of governors. Aided by professional staff, the members work together through Divisions of Family and Child Welfare, Public Welfare, Corrections, and Community Funds and Councils, and through special committees on such subjects as education and personnel for the social services, and aging. Services of the Council include public information and research. The Council publishes periodicals entitled Canadian Welfare, Bien-Être Social Canadien, and The Canadian Journal of Corrections, a directory of Canadian welfare services, pamphlets and bulletins.

The Canadian Diabetic Association. - Formed in 1953 with headquarters in Toronto, the Association has 28 branches established in nine provinces and a French-language affiliate, l'Association du Diabète, in Quebec. The aims of the organization are to promote public education regarding diabetes and the early detection of cases, to teach diabetics self-care, and to conduct research, for example, the Family Tree Research Program. The branches support various services such as free diet counselling and summer camps for diabetic children and adults, and hold 'model schools' or institutes from time to time in many cities.

The Canadian Red Cross Society. - Established in 1896 in Canada, the Society is affiliated with the International Red

Cross and has branches in all ten provinces with national headquarters in Toronto. Its objectives, defined in its Charter, are "... in time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease and the mitigation of suffering throughout the world". Red Cross Society activities are very broad, ranging from national and international disaster relief services to the support of local projects. Its largest single activity in Canada is the operation of the national, free blood transfusion service that keeps hospitals supplied with blood provided by voluntary donors. The Society also conducts important health services including hospital and nursing outposts, homemakers service, sickroom supply loan service, and instruction in water safety and home nursing. The Junior Red Cross promotes health education through its schoolroom branches across Canada; it supports a special fund to supply treatment to needy handicapped children in Canada and a fund to promote understanding among school children of different countries.

The Canadian Rehabilitation Council for the Disabled.- This national agency situated in Toronto was formed in 1962 by the merger of the Canadian Council for Crippled Children with the Canadian Foundation for Poliomyelitis and Rehabilitation. To further its object of co-ordinating activities in all areas for the rehabilitation of the disabled, the Council works with other voluntary agencies concerned with specific disease groups or services. It also carries out such functions as consultative services, public education, and research in this field. In some provinces, these two organizations have also merged to provide treatment, training, and other patient services to disabled persons not reached by existing agencies. In other provinces, the handicapped-children's societies administer case-finding, restorative, and related services including parent counselling, camping, and recreation; such programs are financed by Easter Seal campaigns. The foundations for the disabled in these provinces, financed by the March of Dimes or community chests, provide similar services to disabled adults with more emphasis upon vocational rehabilitation.

The Victorian Order of Nurses.- Since its inception in 1897, the Victorian Order of Nurses has provided a professional home nursing and health counselling service to patients with any type of illness and regardless of their financial status. In all provinces except Prince Edward Island, the association's nurses carry out, under medical direction, bedside nursing, with emphasis upon chronic conditions, and prenatal, postnatal, and newborn care. In some provinces they also assist provincial health authorities in tuberculosis and venereal disease programs and conduct child-health clinics. Through some 120 branches, VON services are available to over one-third of Canada's population. The national office is in Ottawa.

The Canadian National Institute for the Blind.- Since 1918 the Canadian National Institute for the Blind has been the only national agency providing a complete social welfare service to the blind and prevention services to the visually impaired. The national office, located in Toronto, supports eight regional divisions covering all provinces and 50 local branches serving 24,700 registered blind persons and over 100,000 prevention cases in 1962-63. Through its Eye Service, free to those in need of assistance, the Institute arranges for eye examinations and pays for medical treatment, glasses, and visual aids; it also supports the operation of several Low Vision Aid Clinics and Eye Banks in the main cities. Vocational, recreation, and educational services for the blind are provided at 20 residential and service centres located across the country. Home teachers visit the newly blinded of all ages including pre-school-age children to teach them independence in daily living and other skills such as Braille, typing, and handicrafts. Placement officers furnish vocational counselling and arrange for training and employment. Where possible the blind are placed in jobs in general industry, in CNIB canteens, or in farming and small businesses; others are employed in the Institute's sheltered workshops. The National Library circulates Braille magazines and books and recordings and supplies a transcription service to students.

The Health League of Canada.- The Health League of Canada, first established in 1918 as the National Committee for Combating Venereal Disease, now supports a wide variety of public health education activities to prevent disease and raise health standards. The League co-operates with health departments and other national health organizations in disseminating health information. Its technical divisions are concerned with various aspects of public health such as immunization, child and maternal health, fluoridation of water, industrial health, nutrition, gerontology, and other fields. In co-operation with its affiliates, the League administers its program from the national office in Toronto; certain branch activities for the province of Quebec are conducted through its Montreal and Quebec offices. Educational efforts include the provision of speakers for meetings, the preparation of radio scripts, health education films, and the publication of the magazine Health and various bulletins. The League sponsors National Health Week and National Immunization Week.

The St. John Ambulance Association.- The Order of the Hospital of St. John of Jerusalem began as a local unit in Montreal in 1884 and was incorporated on a national basis in 1910 with headquarters in Ottawa. The organization, which has established nine Provincial Councils, is composed of two parts -- the St. John Ambulance Association and the St. John Ambulance Brigade. The Association teaches first aid,

home nursing, and artificial respiration, and is used extensively by Civil Defence, Armed Forces, workmen's compensation, and industrial personnel, while the Brigade directs an emergency corps of trained personnel. Provincial and local units operate training courses, first aid posts, ambulance services, and other activities such as ski patrols. The Association has also organized seven Special Centres for training purposes in several federal government agencies and private industries.

The Canadian Tuberculosis Association.- Founded in 1900 to increase treatment facilities for tuberculosis patients, the Association's objective is the control and ultimate eradication of tuberculosis. Recently, it has also extended its interest to other thoracic diseases. The national office in Ottawa and the provincial and local branches in each province co-operate with the public health agencies in promoting adequate facilities for prevention, diagnosis, treatment, and rehabilitation. The provincial associations assist in case-finding by means of mass X-ray and tuberculin-testing surveys of specific areas and higher risk groups, and carry out extensive health education work; some associations also participate in follow-up and rehabilitation of patients. Publication of educational materials and periodicals, organization of the annual Christmas Seal campaign, and research are centred in the national office. It also makes its consultant services available to federal and provincial health departments.

The National Cancer Institute of Canada.- The National Cancer Institute, composed of persons representing professional societies and agencies concerned with cancer research and therapy, was founded in 1947 to develop a nationally co-ordinated research and professional education program. The Institute supports cancer research projects at universities, hospitals, and its own research units, maintains the Canadian Tumour Registry, provides research fellowships, and, in co-operation with the Canadian Medical Association and medical schools, promotes the post-graduate training of radiation physicists and professional education on cancer topics. It also provides an important statistical service by assisting treatment centres in designing clinical trials and developing standard data on cancer problems. The Institute receives financial support from federal-provincial grants and from the Canadian Cancer Society.

The Canadian Hearing Society.- Organized in 1940 as the National Society of the Deaf and the Hard of Hearing, the Society has offices in Toronto, Ottawa, and London. It is concerned with the preservation of hearing, the treatment of deafness, and the provision of rehabilitation services for those with impaired hearing, including war veterans and children. It provides hearing examinations, counselling,

vocational guidance, and job placement services for the deaf or hard-of-hearing, and hearing aids to indigent persons. It also works closely with the two Ontario Schools for the Deaf. The Society publishes The Hearing Eye and distributes educational material on request.

The Canadian Mental Health Association.- Since its organization in 1918 as the National Committee for Mental Hygiene, the Association has promoted mental health and the best possible care of the mentally ill. Its program of public education, professional and lay training, services to the mentally ill, consultative services, and research is carried out by the national office in Toronto, and its provincial divisions and community branches. To develop public understanding of mental health principles, the Association sponsors discussion groups and prepares a variety of educational materials for the press, radio, and television and for professional personnel. Services to mental patients have grown rapidly as branches have established information and referral centres, volunteer hospital visiting programs, White Cross social centres, foster-home care, and other personal services for patients and their families. Through various studies of mental health problems and the National Mental Health Research Fund, set up in 1957, the Association has stimulated new approaches to prevention and treatment in this field.

The Canadian Arthritis and Rheumatism Society.- This group was formed in 1948 to help persons suffering from the rheumatic diseases by a program of treatment, research, and education. Through its national office in Toronto, eight provincial divisions, and local branches in most towns, the Society has assisted many hospitals to establish arthritis clinics and several to set up rheumatic disease in-patient units, and it provides a home physiotherapy service in the larger cities covering about one-half of the population. Five of the divisions provide mobile consultation services to patients and doctors in rural areas. In 1962, over 13,500 patients benefited from treatment or consultative services from the Society's professional staff of over 100, mostly physiotherapists. The Society also supports clinical and epidemiological research projects and sponsors the regular Canadian Conference on Research in Rheumatic Diseases. Other activities include public educational services stressing early diagnosis and treatment, and the professional training of arthritis specialists.

The Canadian Cancer Society.- Organized in 1938 to coordinate voluntary activities and disseminate knowledge in the cancer field, the Canadian Cancer Society operates in all provinces and has its national office in Toronto. Its chief services are a public education program, welfare services

such as transportation, home nursing, and dressings to cancer patients, and the promotion of medical research through support of research facilities and fellowships for advanced study. Voluntary subscriptions to the Society provide about 80 per cent of the funds for the Research Units of the National Cancer Institute of Canada. The Society also sponsors clinical research projects in other institutions.

The Canadian Heart Foundation.- The Canadian Heart Foundation was formed in 1947 by physicians to co-ordinate research and disseminate information. Its membership consists of lay and medical individuals and organizations interested in promoting cardiovascular research and in both public and professional education. The Foundation makes available grants-in-aid to support various medical research projects and fellowship awards to promising scientists in co-operation with the medical schools and teaching hospitals. Its projects are financed by voluntary donations to the Canadian Heart Fund as well as by federal and provincial grants. The Foundation has established provincial foundations covering all provinces and a national office in Toronto.

The Canadian Paraplegic Association.- The Association was formed in 1945 by a group of paraplegic veterans to ensure provision of adequate treatment and rehabilitation facilities for all persons suffering paralysis caused by disease or injury. Through its national office in Toronto and seven divisional and local offices, the Association's rehabilitation program makes available physical restoration, counselling, and vocational services, prosthetic appliances, and personal aids and other activities to promote the social well-being of paraplegics. A comprehensive service is provided at Lyndhurst Lodge Retraining Centre in Toronto, owned by the Association; elsewhere it arranges for these services with various hospitals and other rehabilitation agencies.

The Multiple Sclerosis Society of Canada.- The Society has been organized since 1948 to support research in multiple sclerosis and allied diseases and to educate the public on the social problem of multiple sclerosis. Its 29 local chapters located in eight provinces raise funds mainly for research but they also provide welfare services to patients in need of wheel chairs and other personal aids. Grants for its medical research projects and fellowships are administered from the national office in Montreal. Local chapters have undertaken patient registries.

The Canadian Association for Retarded Children.- The Association was incorporated in 1958 to co-ordinate the work of organizations for the mentally retarded, now represented by ten provincial and about 250 local groups.

Membership of the local groups exceeds 14,000, most of whom are parents of mentally retarded children. The Association promotes the establishment of assessment clinics, day-training classes, sheltered workshops and activity centres, summer camps, and recreational programs; it also supports research into the causes of mental deficiency. The Association operates over 530 special classes and 20 sheltered workshops for trainable retarded children and adults. Financial support comes from local fund-raising campaigns, community chests, and, in varying degrees, from provincial education and other departments. The national office is in Toronto.

The Muscular Dystrophy Association of Canada. - This Association was organized in 1954 to stimulate and unify research efforts into the cause, nature, and treatment of muscular dystrophy and related diseases and to promote the establishment of facilities for diagnostic, consultative, and treatment services. Under the direction of a national office in Toronto supported by 33 local chapters, its chief activity is the sponsoring of basic and applied research projects in medical schools and other centres across the country. Other activities include providing appliances and transportation to muscular dystrophy patients and supplying information to the public and professionals.

The Canadian Cystic Fibrosis Foundation. - This recently organized national agency has 19 affiliated chapters located in seven provinces. Its objects are to aid patients with this inherited condition, and to promote research, professional training, and public understanding. Several chapters have established clinics for the diagnosis and treatment of cystic fibrosis among children, and all provide patient services including special drugs and equipment. The Foundation initiated its research program in 1962, and intensified the distribution of educational material to parents and the general public. The national office is in Toronto.

Voluntary Medical Insurance. - About 11,700,000 Canadians, or 61 per cent of the population of Canada, had voluntarily secured some protection against the costs of physicians' services at the end of 1964. Their protection was provided by some 62 nonprofit plans with an enrolment of 6,450,000 and 79 private companies giving coverage to an estimated 5,260,000 persons. The total was 5,800,000 above the 1955 figure, which represented only 40 per cent of the population.

The nonprofit plans took in about $186,000,000 in premiums and $4,200,000 in other revenue in 1964, paid out $173,000,000 in benefits and $13,400,000 for administration, and were left with a surplus of approximately $3,800,000. Thus, for every

dollar of premiums, 93 cents were paid out in benefits, which amounted to approximately $26.98 per person covered. In 1955, benefit payments had been $41,400,000, representing 89 cents of the premium dollar and amounting to only $13.17 per person.

Profit-making private companies wrote $119,700,000 of premiums for health protection in 1964. They paid out $92,000,000 in claims.

Health and welfare services in Canada